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Dedication

To military nurses
who throughout history
have supported our country
through their love and caring of others.

ATTITUDES, POWER, AND ABILITY TO CARE AMONG

U. S. AIR FORCE MENTAL HEALTH NURSES:

A DESCRIPTIVE STUDY

by

Mary Mickle Higgins, B.S.N, R.N.C.

THESIS

Presented to the Faculty of the Graduate School of

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in Partial Fulfillment

of the Requirements

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I am so grateful to my family for their commitment and sacrifice while I have worked, at all hours, on my studies and research. My son Jeremiah and my daughter Leah have supported me with evening shoulder rubs, lots of hugs, and low television volume. What more could a mother ask for? I am thankful for the support and love of Christopher, my husband, whose positive inspiration has remained consistent each and every day. He believed in me and my abilities even at times when I felt overwhelmed and frustrated, and he knew what I needed even before I knew it myself.

My most sincere thanks to the U.S. Air Force mental health nurses who participated in this study. Their willingness to take time out of their busy schedules and share their perceptions is responsible for the success of this study. Without them, this research contribution to nursing would not have been possible.

ABSTRACT

ATTITUDES, POWER, AND ABILITY TO CARE AMONG

U.S. AIR FORCE MENTAL HEALTH NURSES:

A DESCRIPTIVE STUDY

by

MARY MICKLE HIGGINS, B.S.N., R.N.C.

SUPERVISOR: CAROLYN KINNEY, Ph.D., R.N.

Air Force mental health nurses provide care for patients in an environment differing from most civilian hospital settings. On an in-patient unit, which consists mainly of active duty military patients, there is a strong emphasis placed on evaluating the ability of the patient to perform their military duty. Society's negative attitudes toward mental illness are often even more evident within the military environment toward active duty personnel needing mental health care. If the organization to which the client belongs does not accept a client with mental illness, can the nurse, who works for the same organization, accept the client with mental illness?

A descriptive study of 144 Air Force mental health nurses looks at the relationships among their attitudes toward mental illness, their sense of power within the military environment, and their ability to care. Using the

nursing theory *Modeling and Role-Modeling* (Erickson, Tomlin, & Swain, 1990) a framework is provided which addresses the need of the nurse to approach the client with empathy and unconditional acceptance, as well as the nurses' role within the organizational system. The survey includes the use of three tools which measure attitudes toward mental illness, power within the work environment, and the nurses' ability to care. Significant correlations were found between these variables. Qualitative responses were found to be rich with descriptions of aspects which affect these nurses' ability to care for their patients.

Therefore, the purpose of this study is to examine these relationships of attitudes, power, and ability to care for improvement of client/nurse relationships and improved client outcomes in the patient-care setting.

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CHAPTER I

INTRODUCTION

Air Force psychiatric nurses provide care for patients in an environment differing from most civilian psychiatric hospital settings. In the military, there is an overall focus on the "needs of the military" rather than the "needs of the client." On an in-patient unit, which consists mainly of active duty military patients, emphasis is placed on evaluating the ability of the patient to perform their military duty. When it is determined that these individuals have illnesses and problems that are incompatible with military requirements, regulations dictate that they must be separated from the military.

Since the military environment and its traditional power structure creates many negative attitudes toward active duty personnel needing mental health care the nurses' acceptance of such a patient as unique, worthwhile, important, and respected may be hampered. If the organization to which the client belongs does not accept a client with mental illness, can the nurse, who works for the same organization, accept the client with mental illness?

The ability of the nurse to provide a nurturing, caring approach to patients in this environment is difficult because such an approach requires the nurse to view the client with empathy and unconditional acceptance. Erickson, Tomlin, and Swain (1990) describe unconditional acceptance as a

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necessary component of the nurse's role if clients are to be assisted to grow toward their potential.

PURPOSE

The purpose of this descriptive study was to survey Air Force mental health nurses to examine the relationships among their attitudes toward mental illness, their sense of power within the military work environment, and their caring ability.

RESEARCH QUESTION

The following questions provide the basis for this study: (1) What is the relationship between Air Force mental health nurses' attitudes toward their patients and their ability to care? (2) What is the relationship between Air Force mental health nurses' attitudes toward their patients and their sense of power within their work environment? (3) What is the relationship between the Air Force mental health nurses' ability to care and their sense of power within their work environment?

DEFINITION OF TERMS

1. **Air Force Psychiatric Nurse:** Any active duty psychiatric/mental health nurse, currently serving in the U.S. Air Force, and having at least one year of military experience as a psychiatric/mental health nurse.

2. **Nurses' Attitudes Toward Mental Illness:** Learned opinions and feelings toward psychiatric patients and mental illness within the military setting.

3. **Caring Ability:** The capacity of the nurse to connect and establish a unconditional accepting relationship with a client.

4. **Power:** Being aware of what intervention the nurse would like to do, feeling free to do the intervention, and then acting intentionally to perform the intervention.

BACKGROUND AND SIGNIFICANCE OF THE STUDY

The study, based on the nursing theory *Modeling and Role Modeling* (Erickson, Tomlin, & Swain, 1990), is significant with respect to the nurse's relationship with the client. Within an institutional system, the nurse must maintain an effective relationship with not only the client, but also with the physician and institution. A complex institutional system such as the military can create barriers to the nurses' ability to develop a relationship with the client, if all the nurses' time and energy is focused on the relationship with the institution. *Modeling and Role Modeling* presumes that an effective

therapeutic nurse/client relationship requires a relationship independent and separate from the nurse/physician and nurse/institution relationship.

As a nurse practitioner, I have spent the last four years observing the relationships between the nurses and clients on an in-patient Air Force psychiatric unit in the United States. These relationships appeared to be more distant than the type of relationships I observed the previous four years in a civilian setting. Perhaps the unacceptability of mental illness within the military is a contributing factor in the nurses inability to unconditionally accept their clients as *Modeling and Role Modeling* (Erickson, Tomlin, & Swain, 1990) suggests. Continuously observing clients who are being separated from the military may interfere with the nurse's ability to maintain caring behavior. Power issues associated with authority and rank structure may lead nurses to follow a medical model instead of a nursing model in establishing client relationships and providing client care. While none of these areas can be answered conclusively by this study, perhaps some insight can be obtained which reflects areas needing further study. Also, this knowledge may be used for improving nurses' ability to care for clients within the Air Force mental health system.

CHAPTER II

REVIEW OF THE LITERATURE

Chapter II is organized into sections pertinent to the three variables in this study: attitudes, power, and caring. While each of these variables are found in the literature, no studies were found relating all three to each other.

REVIEW OF THE LITERATURE ON ATTITUDES

Attitudes are opinions or predisposed responses to an object (individual or thing) in a consistently favorable or unfavorable manner, which may result in various different behaviors toward that object, and provide a frame of reference helping individuals organize their beliefs and impressions of others (Moss, 1988). Attitudes are learned or acquired and are not innate. They are related to characteristic actions and behaviors which are consistent and observable, and can be measured on a continuum from positive to negative (Lopez, 1991).

Caine and Smail (1968), using a 75 item questionnaire titled *Opinions about Mental Illness* (OMI), studied psychiatric nurses' attitudes and roles (N=120). They found that nurses' attitudes toward their work are determined by complex interactions among the following: (1) personal beliefs, (2) biases in training, (3) general atmosphere of the hospital, and (4) ideology of the hospital. The nurse's approach to patient care was based

on attitudes, beliefs, and personality. This classic study is the first found which focused specifically on psychiatric nurses' attitudes toward their patients. The instrument has been used in various other studies looking at attitudes of other populations toward mental illness. Use of the OMI questionnaire was considered for use in this study; however, many of the items on the questionnaire were determined to be outdated and not specific enough for this target population.

A qualitative study by Kavanagh (1988) examined the cost of caring for nurses on psychiatric intensive care unit. The researcher collected data while spending 10 months as a participant-observer at three different city and county psychiatric facilities. Focal points included nursing interaction with patients, the work environment, medical and administrative staff, the psychiatric/mental health system, larger society, and nurses with each other. Attitudes shared by nurses in this study included the following: (1) mental illness as a whole was viewed by nurses as too overwhelming to deal with and needed to be kept to an individual level; (2) the pressures of work and the severity of a patient's illness prevented the development of a one-to-one relationship with the patient; (3) expectations and goals for mentally ill patients were markedly limited; (4) nursing roles were focused on medication management; (5) there was a need by nurses to label patients

with a diagnosis for the purpose of predictability; (6) the nurses believed that what they do, and the patients they work with, are valued little by society; (7) there was little belief that nursing interventions with these patients had a lasting effect; (8) improvements with individual patients are lost within the mental health system and society as a whole; (9) experienced nurses frequently disagreed with medicines and dispositions; (10) nurses often avoided working with their patients on an emotional feeling level; and (11) immediate crisis resolution was of greater focus by nurses than long-term patient oriented interventions. This study by Kavanagh was found to be the most informative and helpful in developing the *Nurses' Attitudes Toward Mental Illness Questionnaire*, designed for use in this study. Many of the statements described in Kavanagh's study were familiar to this author from personal practice experiences.

Kavanagh (1989) studied obstacles and challenges to nurses' networks. The study identified that management roles are focal in shaping staff nurses' attitudes toward hierarchical superiors, the systems they represent, peers, their work, and perhaps themselves. Nurses struggle for autonomy, status, and recognition when they are dependent on the medical hierarchy frequently found in the hospital system. Patient care and outcomes, nurses' role expression, ideology, and occupational identity were

closely related to nurses' networks. This study emphasizes the need for nurses to perform nursing independent of the medical system model, with more of a focus toward a nursing model of client care.

Attitudes toward mental illness within the military environment have been negative throughout history. An example cited by Gabriel (1986) was that of a soldier who had "broken down" in combat. The soldier was slapped in public by General Patton who viewed him as a coward with poor moral character. Whether a member of the military service is allowed to return to duty after experiencing a mental illness varies greatly and depends on command policy at the time. Individuals unable to return to duty must undergo medical and physical evaluation boards (MEB/PEB) to determine disposition and benefits. Fragala and McCaughny (1991) described case studies of suicide following the MEB/PEB process and concluded that military individuals with mental illness who cannot return to duty suffer withdrawal from staff attention and have to face the end of their military identity, not just their career. They face the stigma of having mental illness and no longer feel safe. The loss of identity and loss of military career is more than the individual can often bear.

The study by Pines and Maslach (1978), which is discussed more extensively in the literature review on power, had many areas applicable

toward attitudes of psychiatric nurses toward their patients. Results of this study identified six important aspects pertaining to psychiatric nursing:

(1) work is less stressful if the work is shared; sharing of work related to increased freedom of expression, input into institutional policy, and feelings of personal power; (2) the quality of interactions between staff and patients was related to the staff members' perceptions of the institution, other staff members, their work, and their patients; (3) work relationships improve where there are fewer seriously ill patients and fewer work hours;

(4) frequency of staff meetings was correlated with negative dehumanizing attitudes toward patients; (5) as outlook outcomes for patients decreased (ie., schizophrenia with little chance of recovery), attitudes toward patients decreased and involvement with patients decreased; and (6) the longer the staff member is in the mental health area, the poorer the attitude toward the patients. These results are particularly applicable to Air Force psychiatric nursing because nurses in this environment remain on in-patient units with the sickest psychiatric patients, they seldom observe favorable outcomes (ie. patients who keep their jobs and return to duty), and they work in an environment where mental illness is not acceptable.

REVIEW OF THE LITERATURE ON POWER

Barrett (1986) describes power as an interaction between individuals and their environment to produce some occurrences rather than others, thereby participating in change to create reality. It is being aware of what needs to be done within the individual's environment, making a choice to do it, having the freedom to do it, and then being able to act intentionally to do what needs to be done (Barrett, 1986). This description focuses on change within the environment of individuals, particular to change, but fails to acknowledges the relationship aspect associated with individuals.

Erlen and Frost (1991) state that the degree of power an individual has is based on the extent of the *imbalance* within a relationship, and that perceptions of power or powerlessness require a relationship to be in existence. This description presumes that within a relationship, there must be two opposing positions - one that is strong and the other weak. An example used to look at power within this context examines the nurse - physician roles, and how they are portrayed by the media. Historically, nurses have been portrayed by media as less knowledgeable and less competent (Kalish & Kalish, 1987).

Rankin (1988) states that power does not mean dominating or controlling another, but simply exercising the ability to get things done. An

analogy is drawn to hospital organizations, resembling family systems, which represent a parental power relationship with a child. Kidder and Grueding (1989) state that power is neither good nor bad, but occurs within any relationship. Nurses need power to practice nursing effectively and care for clients (Kidder & Grueding, 1989). Knowing, or being in the know, is one way in which power is held. Creating barriers of isolation within a nursing group deprives nursing of both information and solidarity that could otherwise be supportive. These barriers are traditionally found within a hospital hierarchy (Campbell, 1990).

In relation to caring, Huston and Marquis (1988) state that there is power in caring and that the powerful nurse cares for her clients, colleagues, and self. Power within nursing can lead to desired client care practices, gain desired resources, implement new ideas, and is responsible for bringing about change. They address that many nurses feel powerless within the current system. Sinda (1984) states that powerlessness experienced by the nurse leads to frustration, bitterness, low morale, poor performance, and decreased quality client care. Sinda goes on to describe that this powerlessness draws the nurse to identify with power which focuses more on medicine and hospital management, and the physicians' concept of nursing. In conclusion, "nurses constitute a group of employed personnel not

individually accountable to the clients they serve, but to the institution that employs them" (Sinda, 1984, p. 124). This description of results of powerlessness closely resembles what is termed within the literature as "burnout."

While it is not the intent of this author to look at the topic of burnout specifically, a study (N=76) by Pines and Maslach (1978), describing burnout behaviors among psychiatric nurses, is applicable to the topic of power and powerlessness. Using questionnaires on self perception, attitudes toward mental illness, and attitudes toward job, they concluded that the results of burnout lead to physical and emotional exhaustion, negative self-concept, negative job attitude, and loss of concern and emotional feelings for the clients. The techniques used by psychiatric nurses to fight burnout included five areas: (1) Detachment concern: the need to distance one's self in order to help the client; (2) Intellectualization: objectifying the situation and making the situation less personal; (3) Compartmentalization: a distinct separation of job and work from personal life; (4) Withdrawal: spending less time with clients, minimizing involvement, with a greater emphasis on impersonal communication; (5) Social techniques: turning to others for advice, comfort, and as a tension reducer.

Power is defined by Bush (1988) as "the capability of one social actor to overcome resistance by another social actor in achieving a desired objective" (p. 719). Within this definition, a social actor can be an individual or an organization, with one having more power with respect to the other within the context of a specific relationship. Bush goes on to describe that power pervades all organizational relationships including those within the hospital. The hospital is comprised of predominately two workforces, nurses and physicians, with both groups having a strong need for independence and autonomy. The power issues associated with these two professional disciplines calls into question other issues of coexistence of multiple authority lines within the organization (Bush, 1988). In the military environment, this may be complicated even further by the rigid rank structure. As an example, a nurse may outrank a doctor; however, the doctor retains decision-making authority.

Rogers (1977) identified the need for people to maintain personal power and their need to receive understanding and caring as a prerequisite for constructive changes. Those persons maintaining power demonstrate more strength, power, and responsibility. Within organizations, members who share power and maintain open communication are more productive and have better morale than those organizations where this does not occur

(Rogers, 1977). This reference links power and caring together in a unique combination as a requirement for positive change, and it can be helpful in looking at nurses' relationships with their clients.

In a quantitative study by Bush (1988), hospital nurses (N=171) were studied to explore the relationship between locus of control and perceptions of powerlessness, and their joint effect on job satisfaction. Subjects were asked to complete a three-part questionnaire looking at variables of job satisfaction, powerlessness, and locus of control. The questionnaire included the *Rotter Internal-External Scale*, the *Health Care Worker Powerlessness Scale* (revised), and the *Job Description Index*. With a response rate of 145 nurses, the most variability in job satisfaction was found to be related to powerlessness. The higher the job satisfaction rate, the lower the rate of powerlessness, as measured by three questionnaires. This study suggests that there is a need for power within the job environment to affect a positive attitude, or vice versa.

Trangenstein (1988) examined the interaction between power and job diversity. Members of the American Nurses' Association (ANA), in three regions of the country (N=326), were mailed questionnaires with a return rate of 78%. One of the instruments used was Barrett's *Power as Knowing Participation in Change Test* (PKPCT). The study found that subjects who

perceive themselves to be knowing participants in a diverse job tended to have feelings of well-being and were able to identify with their jobs. There was a significant relationship (p <.001) among predictor variables of power and job diversity, and the criterion variables of job satisfaction and job involvement. This study supports the importance of relating attitudes within the job environment and power. Taking this a step further, nursing could benefit by relating how these variables affect client care.

Prescott and Dennis (1985), in a descriptive study about power and powerlessness in nursing departments, studied 15 hospital nursing departments in six geographical areas and compared responses of staff nurses with nursing directors/supervisors. In the findings, 14% of the staff nurses reported having input or involvement in their work conditions (job autonomy). Responses reflected lack of power awareness and ineffective use of expertise as a source of power. Positive attitudes of the directors of nursing, role modeling by head nurses, organizational involvement, and clear expectations related to patient care were seen as factors associated with staff nurses' positive perception of their power. It might be beneficial to take this study one step further by looking at the positive perception of power, and how it affect the nurses' ability to care for clients.

In other studies, hospital settings were seen as rigid organizational structures not conducive to power within nursing. Hospital staff nurses (N=190) reported a higher degree of perceived powerlessness than those nurses in educational or supervisory positions (Sands & Ismeurt, 1986). Results revealed that nurses, who perceived having inadequate support from nursing administrators, had higher perceived powerlessness. Sands & Ismeurt (1986) suggest that support from within one's own peer group may have a strong influence on perceptions of roles and powerlessness. The role of powerlessness as it affects the ability of these nurses to care for clients is not discussed.

The unbalanced dichotomy of power between the nurse and physician is described in a qualitative study (N=25) by Erlen and Frost (1991); in this study physicians were described as having more power, control, and dominance when nurses attempted to fulfill their role as patient advocates involving ethical situations. A qualitative study (N=192), which examined the hospital culture, found the emphasis on nursing related solely toward task oriented interventions of the nurse (Ray,1984).

Prescott and Dennis (1985), in a descriptive study of 15 hospitals within six geographical areas (N=265), identified that the power of nursing within the organization was determined by organizational policy. Results

identified that 53% of those staff nurses in the study were involved with policy formation within their work environment. Fourteen percent of staff nurses identified that they had job autonomy with responses reflecting a lack of power awareness and ineffective use of expertise as a source of power. The study recommended the following: an emphasis on developing the head nurse role; increasing power of individual staff nurses on the units; increasing the number of clinical nurse specialists on the units while decreasing the nursing administration levels; increasing the emphasis on nursing autonomy regarding client care; and decreasing emphasis on regulating nursing practice within the unit (Prescott & Dennis, 1985). Military nurses may experience a greater perception of regulating within the system and may experience greater power or powerlessness which may affect their ability to care for clients.

REVIEW OF THE LITERATURE ON CARING

Caring is a process requiring commitment of one's self to others on a personal, social, moral, and spiritual level (Watson, 1988). Caring is not an action, but a way of being, requiring the sharing with another in a mutual relationship on an emotional level, as well as a cognitive level. Caring first requires the will to do so, followed by the intent to care, and last by actions which support the individual's perceptions of their needs (Vezeau &

Schroeder, 1991; Bishop & Scudder, 1991; Gout, 1984). Nightingale (1969)

addressed caring in her *Notes on Nursing* as an ability for an individual to

be sensitive and imaginative in placing ones' self in the world of another.

By contrast, Watson (1988) describes the uncaring person as one who

is "insensitive to another person as a unique individual, non-perceptive of

other's feelings, and does not necessarily distinguish one person from

another in any significant way," (p. 34). The opposite of a caring attitude is

an attitude of indifference; the opposite of a caring act is an act of neglect

(Greenleaf 1991). Benner and Wrubel (1988) state that caring does not

mean having control, dominating, or possessing privileged information about

someone else. They also address that individuals who are continually in

negative situations tend to use self protective measures and detachment to

deal with the situation, resulting in the separation of caregiving and caring.

The ability to care in these situations requires rest, respite, and reintegration

of concern and involvement with those who need care (Benner & Wrubel,

1988).

Unfortunately, when the caregiver fails to care, the focus is placed on

the failure of the caregiver, but does not address the problem of the system

in which the caring occurs (Greenleaf, 1991). Organizations require

measurements and specifications for care, require quantification, and focus

on measurable tasks, ie., patient classification systems. Those areas which cannot be measured and timed do not count within the system (Greenleaf, 1991). It is clear when reviewing literature such as this, and experiencing the priority associated with completing a patient classification, that institutional systems do not focus on caring, but instead on tasks.

The ability of the nurse to provide caring, based on this definition, closely aligns with the concept of nurturance in *Modeling and Role-Modeling* theory (Erickson, Tomlin, & Swain, 1990). The theory states that nurturance requires an understanding of the client's world from the client's perspective, unconditional acceptance of the client as a person, and interventions and actions which are unique for the client. An exploratory study (Geissler, 1990) of female registered nurses concluded that nurturance is a reciprocal interaction used by the nurse to empower clients toward their optimum potential, focusing on their strengths, and assisting them toward regained independence.

In a qualitative study of 20 nurses' experience of caring, the authors concluded that accepting the patient at the individual's developmental level was necessary for the nurse to interact with the patient (Green-Hernandez, 1991). Level of involvement with the patient affects the ability to practice caring, and that caring requires reciprocation from fellow professions via

peer validation (Green-Hernandez, 1991). Within this same study, requirements for professional nurse caring were outlined emphasizing: (1) the need to address the client as a whole and not just the illness; (2) caring must be conveyed by verbal statements and non-verbal demonstrations of being there for the client; and (3) empathy toward the client is derived from the nurse's own life and professional experiences. These concepts are highly supported by the nursing theory of *Modeling and Role Modeling* and parallel those attributes identified as "nurturance" within that theory. Taking the results of Green-Hernandez (1991) a step further, one could surmise that in areas of nursing where clients are stigmatized, nurses do not appreciate the efforts of other nurses, and the emphasis is focused on the institutional system rather than on the client; the consequence of this is that the nurse's ability to care could be jeopardized.

In a study on caring, Clayton, Murray, Horner, and Greene (1991) identified the need for the nurse to "connect" with the client before caring can take place. Connecting was described in four stages of (1) presencing, (2) attending, (3) affiliating, and (4) empowering. Connecting was enhanced by awareness of and sensitivity to patients' needs, nurse/patient personalities, facilitating and advocating to meet clients' needs, and meaningful experiences of the patient that were shared by the nurse. This study

addresses the importance of establishing a relationship with the client as a prerequisite to caring. This may be difficult in areas of nursing where client/nurse relationships take a back seat to nurse/institution relationships.

Leininger (1984) states that caring is the most important part of nursing; however, there is no price placed on caring in our society. Caring is significantly affected by the social structures of the institutions of care (Dunlop, 1986). Barriers to caring include political, legal, and economic systems of bureaucracy within institutional settings (Ray, 1984). This 7 month qualitative study based on interviews with nurses (N=192), examined the hospital culture and identified: (1) values and behaviors held by nurses reflected those held by society; (2) a high focus on the "practical" aspects of care; (3) nurses had unmet needs in areas of personal rewards, providing care, and open communication; and (4) nurses were more "self" oriented than "other" oriented. The "self" orientation of nurses was attributed to their described unmet needs in areas of: (1) lack of personal reward in providing care, (2) failure of open communication within the system, and (3) deficiencies of the nurse's personal economic system (Ray, 1984). This study most clearly represents the importance of nurses having their own personal needs met before they can meet the needs of their client. A

nurse's ability to have the power to participate in change within their work environment could help meet their personal and professional needs.

In a study by Beck (1991) that examined how nursing students perceived caring by the faculty, the qualitative study (N=47) on caring attempted to label caring attributes which nursing students observed in their professors. These included: (1) using an unhurried manner; (2) use of positive gestures; (3) being attentive toward others' feeling; (4) sharing of own experiences; (5) identifying a person as valued and unique; (6) conveying a non-judgmental attitude; (7) patience; (8) supportiveness; and (9) understanding and empathy. In conclusion, the study stated that for successful caring, persons receiving care need to feel respected and valued. While this study was not directed specifically to nurse/client relationships, it does identify areas of caring experienced by nurses early in their profession. Their early experience of having someone care about them, and how they are cared about, may influence how they demonstrate caring toward others in their nursing career.

A study (N=240) done by Weiss (1984) used scales and survey instruments to examine gender-related perceptions of caring in the nurse-patient relationship among undergraduate nursing students. The scales used included: (1) *Social Distance Scale,* (2) *Attitudes of Special Groups Toward*

the Employment of Older Persons' Scale, and (3) *Slater Nursing Competency Rating Scale*. The results concluded that females tend to value verbal caring, nonverbal caring, and technical nursing behaviors. Male individuals in charge positions tend to value the technical components of nursing more than the caring component. The study suggests that because most health-care delivery systems are dominated by male physicians and administrators, the male value of technical competence can be expected to be reflected by the policy of the agency. (Weiss, 1984). This study of perceptions and attitudes of how caring is measured differently between males and females may be even more applicable within the military environment. Not only are the majority of physicians and administrators male, but there is also a greater number of male nurses within the military than in the civilian population.

According to the literature, effective nursing requires the nurse to possess the ability to care, the power to care and provide nursing interventions, and a positive attitude toward the persons they care for. None of the studies reviewed linked these variables of caring, power, and attitude together. The purpose of this study is to examine the possibility of a correlation between these variables.

CHAPTER III

METHODOLOGY

RESEARCH DESIGN

This study used a descriptive survey design to examine the relationship between three variables: (1) attitudes toward mental illness within the military, (2) perceived power within the work environment, and (3) caring ability toward psychiatric patients in the military. The questions examined were: (1) What is the relationship between Air Force mental health nurses' attitudes toward their patients and their ability to care? (2) What is the relationship between Air Force mental health nurses' attitudes toward their patients and their sense of power within the work environment? and (3) What is the relationship between the Air Force mental health nurses' ability to care and their sense of power within their work environment?

OPERATIONAL DEFINITIONS

1.   **Air Force Psychiatric Nurse:** Any active duty psychiatric/mental health nurse, currently serving in the U.S. Air Force, and having at least one year of military experience as a psychiatric/mental health nurse as measured by the *Biographical Data Questionnaire*.

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2. **Nurses' Attitudes Toward Mental Illness**: Learned opinions and feelings toward psychiatric patients and mental illness within the military setting as measured by the *Nurses' Attitudes Toward Mental Illness Questionnaire* (NATMI) developed by the author.

3. **Caring Ability**: The capacity of the nurse to connect and establish a unconditional accepting relationship with a client as measured by the *Caring Ability Inventory* (CAI) (Nkongho, 1990).

4. **Power**: Being aware of what intervention the nurse would like to do, feeling free to do the intervention, and then acting intentionally to perform the intervention, as measured by *Power As Knowing Participation in Change Tool* (PKPCT) (Barrett, 1990).

SAMPLE

The sample for this study consisted of approximately 144 active duty Air Force psychiatric/mental health nurses having at least one year of military experience as a psychiatric/mental health nurse. A list of these nurses was obtained through the U. S. Air Force. Survey instruments were mailed to these individuals in early fall. Because the sample and target population were the same, no random sampling technique was necessary.

METHODS OF DATA COLLECTION

Instruments

Four instruments were included in the survey: (1) the *Nurses'
Attitudes Toward Mental Illness Questionnaire*, (2) the *Caring Ability Inventory*,
(3) the *Power as Knowing Participation in Change Tool*, and (4) the
Biographical Data Questionnaire. Three questionnaires measured the study
variables of attitudes, caring, and power. A biographical data questionnaire
was used to obtain demographic data. Also, this form included a request
that the participants describe aspects of their work environment which affect
their ability to care for patients.

Nurses' Attitudes Toward Mental Illness Questionnaire (NATMI)

The Nurses' Attitudes Toward Mental Illness Questionnaire (NATMI)
(Appendix C) is a 30 item Likert type survey developed by the author for
the purpose of this study. No existing tools were found which specifically
applied to mental health nurses in the military environment and their
attitudes toward patient care. Each item contains a 5 point Likert-type
response. Positively worded items with a high number indicate a positive
attitude; a lower number indicates a more negative attitude. Scoring of the

instrument can range from 30, representing the extreme negative attitude to 150, representing the extreme positive attitude. This instrument was analyzed for content validity by three experts in the field of mental health. Items for the tool were based on a qualitative study by Kavanagh (1988) which focused on psychiatric nursing attitudes on an in-patient unit. Comments disclosed by the nurses in Kavanagh's (1988) study, as well as clinical observations by this author, were used to develop the items. The tool was piloted with a sample of 20 Air Force nurses of various backgrounds currently assigned at the University of Texas at Austin and the University of Texas at San Antonio for the purpose of clarity and consistency. Reliability of the pilot survey produced a Chronbach's alpha of .88. Test-retest reliability could not be performed because of inability to use identifiers with the sample.

The Caring Ability Inventory (CAI)

The Caring Ability Inventory (CAI) (Nkongho, 1990) (Appendix D), is a 37 question Likert-type questionnaire which analyzes the subjects' descriptions in an effort to uncover the meaning of caring. It was developed to attempt to measure an individual's ability to care. The questionnaire contains three subscales: (1) "knowing," measured by 14 items:

(2)"courage," measured by 13 items: and (3) "patience," measured by 10 items.

The CAI is self-administered, requiring only the written directions provided at the beginning of the inventory. The Likert-type responses range from 1 to 7. Positively worded items with a higher score indicate a higher degree of caring ability. Negatively worded items with a higher score indicate a lower degree of caring. Total scores for this instrument were reported with a low score below 203.1, a medium score between 203.1 - 220.3, and a high score of above 220.3. Reliability was measured for internal consistency by computing Cronbach's alpha with total CIA at .84, and test-retest for total CIA at .75. Content validity was measured by two experts using the content validity index (Waltz, Strickland, & Lentz, 1984) with an 80 % agreement (Nkongho, 1990). Written permission from the author was obtained prior to use (Appendix K).

Power as Knowing Participation in Change Tool (PKPCT)

The *Power as Knowing Participation in Change Tool* (PKPCT) (Barrett, 1990) (Appendix E) is a 7 point semantic differential scale consisting of 42 items divided into four concept-context combinations of the following: (1) awareness, (2) choices, (3) freedom to act intentionally, and

(4) involvement in creating changes. The greater the perceived power, the higher the number; the less the perceived power, the lower the number. Summation scores reported by Barrett (1990) range from 48 - 336. It was developed in an effort to measure the meaning of operational indicators of power. The survey can be self-administered and written directions at the beginning of the tool are sufficient for the administration. Construct validity through two pilot studies using factor loading ranged from .56 to .70. Subscale reliability through factor analysis was .63 for awareness, .75 choices, .95 freedom, and .99 involvement in change (Barrett, 1990). Reliabilities reported for total scoring of the four concepts was reported at .96 (Trangenstein, 1988). Written permission from the author was obtained prior to use (Appendix K).

Biographical Data Questionnaire

Demographic data was collected on the *Biographical Data Questionnaire* (Appendix F). This information included: age, sex, military rank, number of years as an Air Force mental health nurse, position title, ie., staff nurse. charge nurse. While not the primary focus of this study, an opportunity was provided to the participants to describe their thoughts and feelings related to their ability to care for their patients by asking them the

following: "Please describe any aspects of your environment which affect your ability to care for patients."

Procedure

Surveys were coded with a number corresponding to each name on a separate mailing list. Participants were given three weeks to respond and return the survey. Participants not responding within that time frame were mailed a follow-up reminder postcard (Appendix B) in an attempt to encourage return of the questionnaires. No other effort was made to follow-up on participation. Collection continued for six weeks after reminder notices were mailed.

Protection of Human Rights

Several methods were used to ensure the protection of human subjects in this study. The research proposal was presented to the Departmental Committee of the University of Texas School of Nursing at Austin, Texas, for review and approval. Following this approval, the research topic was presented to the Air Force Institute of Technology, Wright-Patterson Air Force Base, Ohio, for review and approval. The final approval process required submittal of the research proposal and surveys to Randolph Air Force Base, Texas, for review and approval. Approval was

obtained per Air Force policy, and a survey code number, USAF SCN 92-62, was assigned to the survey package prior to mailing.

Participation in this study was entirely voluntary. A cover letter describing the study and packet of questionnaires was sent to each subject (Appendix A). Response to the survey constituted consent on the part of the subject. Participants in the study received no monetary compensation. To maintain confidentiality, codings were used on the survey for the purpose of mailing reminder cards (Appendix B), but no identifying information was placed on the survey. At the end of the study, all identifying data (ie., the mailing list) was destroyed.

Subjects were under no obligation to participate in this study. Respondents were given written assurance that their participation in the study would not jeopardize their association with the U. S. Air Force or the University of Texas at Austin School of Nursing. The benefits were explained to the subjects in the cover letter as offering an opportunity for participants to examine their attitudes toward their job and the patients in their care.

CHAPTER IV

RESULTS

<u>SAMPLE DESCRIPTION</u>

Surveys were mailed to 144 Air Force mental health nurses. There were 95 responses giving a return rate of 65 %. Of the 95 returns, 86 met the criteria for the study (at least one year of active duty military experience in mental health nursing) giving a 60 % useable return rate. Of those useable cases, 44 (51 %) commented on aspects about their environment which affects their ability to care for patients (see appendix E).

Table 1 provides a summary of the sample characteristics. The majority of respondents (54.7 %) were female (N=47) followed closely by male responses of 45.8 % (N=39). The largest grouping of respondents, by age, were between 30 and 44 years old (81.4 %, N=70). Seven percent (N=6) ranged between ages 20 - 29, and 11.6 % (N=10) were 45 years of age and above.

A category called "educational level" on the survey did not ask for highest level, however for the purpose of data analysis, the highest educational level marked on the survey was used. The majority of respondents identified their education level as a BSN at 52.3 % (N=45) followed by an MSN level of 23.3 % (N=20). 12.8 % (N=11) had an MS

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in other than nursing. Those having a BS in other than nursing responded

at 8.1 % (N=7). Three of the respondents (3.5 %) were educated at the

doctoral level.

Experience levels of these Air Force Nurses revealed that 36 %

(N=31) have been registered nurses (RN) for 6 - 10 years. Twenty-six

(30.2 %) have been registered nurses for 11 -15 years. Those with the

experience between 2-5 years responded at 11.6 % (N=10), those between

16-20 years at 15.1 % (N=13), and those over 20 years at 7 % (N=6). A

further breakdown of experience looked at the differences between civilian

and military experience. These responses varied the most with 36 %

(N=31) having 1 - 3 years of civilian RN experience. Followed closely were

those nurses having between 3 - 5 years of civilian experience at 19.8 %

(N=17) and those with less than 1 year comprised 17.4 % (n= 15) of the

respondents. Those with over six years of experience responded at 24.4 %

(N=21). Two subjects did not report this data.

Individuals identifying that they had less than one year of active duty

military experience as a mental health nurse were not included in any of this

data analysis. The majority, 32.6 % (N=28) identified that their careers as

an Air Force mental health nurse were between 3 - 5 years old. The next

largest group, between 1 - 3 years, reported 26.7 % (N=23), followed by the

11 - 15 year group at 17.4 % (N=15), and next by the 6 - 10 year group at 16.3 % (N=14). The 16 year and over group totaled 6 respondents at 8 %.

The participating nurses were asked to describe their current work position. There were 42 respondents (48.8 %) who identified themselves as staff nurses. The majority of respondents were not currently functioning as staff nurses. Those functioning in the charge nurse and assistant charge nurse roles were identified at 32.6 % (N=28), followed by coordinator at 7 % (N=6), and clinical specialist at 2.3 % (N=2). The category of "other" at 9.3 % (N=8) included those in a student status and those working in areas outside of mental health.

The rank variable revealed a large majority were Captains (CAPT) at 66.3 % (N=57), followed by 17.4 % (N=15) Majors (MAJ). Eight First Lieutenants (1LT) (9.3 %), were followed by six percent (N=6) Lieutenant Colonels (LTCOL). Only one Second Lieutenant (2LT) (1.2 %) met the study criteria.

When looking at shift schedules, the majority of respondents 57 % (N=49) identified that they routinely rotate through all shifts. This category also ...cluded those identifying they were on twelve-hour shifts, since this specific category had not been included on the biographical survey form. Thirty-three respondents (38.4 %) identified their usual shift as a day shift.

Only four persons (4.5 %) identified uniquely working other shifts specific

to nights or evenings.

Table 1.

Summary of Total Sample Characteristics (N = 86)

Characteristics	N	Percentage
Sex		
Male	39	45.3
Female	47	54.7
Age		
20-24	1	1.2
25-29	5	5.8
30-34	22	25.6
35-39	27	31.4
40-44	21	24.4
45-49	7	8.1
50 and over	3	3.5
Educational Level		
BS other than Nursing	7	8.1
BSN	45	52.3
MSN	20	23.3
MS other than Nursing	11	12.8
Doctoral	3	3.5

Table 1. (continued)

Characteristics	N	Percentage
Number of Years as a Registered Nurse		
2-5	10	11.6
6-10	31	36.0
11-15	26	30.2
16-20	13	15.1
over 20	6	7.0
Number of Years as a Civilian Registered Nurse		
under 1	15	17.4
1-3	31	36.0
3-5	17	19.8
6-10	11	12.8
over 10	10	11.6
Missing Cases	2	2.3
Number of Years as an Air Force Mental Health Nurse		
1-3	23	26.7
3-5	28	32.6
6-10	14	16.3
11-15	15	17.4
16-20	5	5.8
over 20	1	1.2

Table 1. (continued)

Characteristics	N	Percentage
Current Position		
Staff Nurse	42	48.8
Assistant Charge Nurse	12	14.0
Charge Nurse	16	18.6
Coordinator	6	7.0
Clinical Specialist	2	2.3
Other	8	9.3
Usual Shift		
Days	33	38.4
Evenings	0	0.0
Nights	1	1.2
Rotate All	49	57.0
Other	3	3.5
Rank		
2LT	1	1.2
1LT	8	9.3
CAPT	57	66.3
MAJ	15	17.4
LTCOL	5	6.0

Table 2.

Summary Sample Characteristics of Male/Female

Characteristics	Male(N)	Male%	Female(N)	Female%
Age				
20-24	1	2.6	0	0
25-29	1	2.6	4	8.5
30-34	9	23.1	13	27.7
35-39	12	30.8	15	31.9
40-44	12	30.8	9	19.1
45-49	2	5.1	5	10.6
50 and over	2	5.1	1	2.1
Totals	39	100.0	47	100.0
Educational Level				
BS other than Nursing	5	12.8	2	8.5
BSN	19	48.7	26	55.3
MSN	6	15.4	14	29.8
MS other than nursing	7	17.9	4	8.5
Doctoral	2	5.1	1	2.1
Totals	39	100.0	47	100.0
Number of Years as a Registered Nurse				
2-5	6	15.4	4	8.5
6-10	11	28.2	20	42.6
11-15	15	38.5	11	23.4
16-20	5	12.8	8	17.0
over 20	2	5.1	4	8.5
Totals	39	100.0	47	100.0

Table 2. (continued)

	Male (N)	Male%	Female(N)	Female%
Number of Years as a Civilian Registered Nurse				
under 1	4	10.3	11	23.4
1-3	17	43.6	14	29.8
3-5	11	28.2	6	12.8
6-10	4	10.3	7	14.9
over 10	2	5.1	8	17.0
missing data	1	2.6	1	2.1
Totals	39	100.0	47	100.0
Number of Years as an Air Force Mental Health Nurse				
1-3	8	20.5	15	31.9
3-5	12	30.8	16	34.0
6-10	5	12.8	9	19.1
11-15	9	23.1	6	12.8
16-20	4	10.3	1	2.1
over 20	1	2.6	0	0.0
Totals	39	100.0	47	100.0
Current Position				
Staff Nurse	16	41.0	26	55.3
Assistant Charge	7	17.9	5	10.6
Charge Nurse	6	15.4	10	21.3
Coordinator	4	10.3	2	4.3
Clinical Specialist	2	5.1	0	0.0
Other	4	10.3	4	8.5
Totals	39	100.0	47	100.0

Table 2. (continued)

	Male(N)	Male%	Female(N)	Female%
Usual Shift				
Days	19	48.7	14	29.8
Evenings	0	0.0	0	0.0
Nights	0	0.0	1	2.1
Rotate All	17	43.6	32	68.1
Other	3	7.7	0	0.0
Totals	39	100.0	47	100.0
Rank				
2LT	1	2.6	0	0.0
1LT	3	7.7	5	10.6
CAPT	22	56.4	35	74.5
MAJ	9	23.1	6	12.8
LTCOL	4	10.3	1	2.1
Total	39	100.0	47	100.0

DISCUSSION OF INSTRUMENTS

The internal consistency of all scales used in this study were assessed by using Chronbach's alpha. Reliabilities, means, and standard deviations are reported in Appendix G. All instruments used in this study had alpha coefficients greater than .80. Total scores for each survey were used for measurement of the variables.

NATMI alpha for this study is .82, based on 78 complete cases. Eight of the cases were missing one or two responses. The pilot test of this instrument produced an alpha of .88. Responses ranged from 1-5 for each of the 30 questions with the group mean response at 3.27 and. a group mean total score of 97.91, and a standard deviation of 12.25. Individual scores ranged from 70 to 128. Possible ranges spanned from 30-150. The mean score was well above the median of the possible range.

CAI alpha for this study is .87 in contrast to the .84 reliability reported by the author. The current reliability is based on 77 complete questionnaires. Eight of the cases had one question with missing data, and one case had three questions with missing data. The questions missed appear random in nature and most likely were the result of oversights on the part of the subjects. Responses for each of the 37 individual items, which

could range from 1-7, revealed a group mean of 5.54. The group mean total score was 204.79 with a standard deviation of 19.13. Individual scores ranged from 147 to 249.

PKPCT alpha for this study was .97. This result is slightly higher than the .96 result obtained by Trangenstein (1988). This reliability is based on 75 complete cases with no missing data. The response for individual items could range from 1-7. The group individual item median was 5.50. The group mean total instrument score was 287.72 with a standard deviation of 44.00 and a range of 158 to 364.

DATA ANALYSIS

Research Question # 1: What is the relationship between Air Force mental health nurses' attitudes toward their patients and their ability to care? In examining the relationship between Air Force mental health nurses attitude toward mental illness within the military, and their ability to care, the two-tailed Pearson r indicated a moderate positive correlation coefficient of .3081 which was significant at the .01 level.

Research Question # 2: What is the relationship between the Air Force mental health nurses' attitudes toward their patients and their sense

of power within the work environment? The nurses attitudes toward their patients and their sense of power within the work environment revealed a moderate positive correlation coefficient of .5159 significant at the .01 level.

Research Question # 3: What is the relationship between the Air Force mental health nurses' ability to care and their sense of power within their work environment? The nurses' ability to care for their patients and their power within their work environment was the strongest of the three correlations at .5532 significant at the .01 level. Polit and Hungler (1991) suggest that correlation between psychosocial variables range typically from .10 to .40. The correlations within this study meet or exceed these expected measurement ranges.

Table 3.

Correlation Coefficients Matrix

	Attitude	Power	Caring
Attitude	1.0000	.5159 **	.3081 **
Power	.5159 **	1.0000	.5532 **
Caring	.3081 **	.5532 **	1.0000

** = $p < .01$

To look at these significant correlations more closely, a split file two-tailed Pearson *r* correlation was run looking at male and female samples separately.

In the male sample (N=39), a correlation of .3963 significant at the .05 level was obtained between the variables of attitude toward patients and ability to care. The variables of attitude toward their patients and sense of power within the work environment measured with an *r* of .5656 significant at the .01 level. The third correlation for the male sample examined the relationship between the variables of the Air force mental health nurses' ability to care and their sense of power within their work environment. The corresponding correlation was .5094 significant at the .01 level.

Table 4.   <u>Correlation Coefficients for Male Sample</u>

	Attitude	Power	Caring
<u>Attitude</u>	1.0000	.5656 **	.3963 *
<u>Power</u>	.5656 **	1.000	.5094 **
<u>Caring</u>	.3963 *	.5094 **	1.000

** = p<.01   * = p<.05

Among the female sample (n=47) the results were slightly different. A significant (p<.01) moderate positive correlation of .4726 occurred between the variables of attitude toward mental illness and their patients and the power within the work environment. Another significant (p<.01) correlation of .5921 occurred between the variables of ability to care and the power within the work environment. The relationship between the variables of attitudes and ability to care revealed a correlation of .2076 but was not found to be significant.

Table 5.   **Correlation Coefficients for Female Sample**

	Attitude	Power	Caring
Attitude	1.000	.4726 **	.2076
Power	.4726 **	1.000	.5921 **
Caring	.2076	.5921 **	1.000

** = p<.01

Biographical data was rank ordered for the purpose of examining relationships between the biographical variables, and with those of the study variables of attitude, power, and caring. A Spearman *r* was used to examine the relationships between these variables, except for the variable of sex. Table 6 summarizes the results.

The variable of shift work schedules was rank ordered based on an assumed "least preferred" to "most preferred." This order was established based on the author's experience in which most Air Force nurse colleagues shared that they prefer day shift, followed by evenings, nights, and finally rotating shifts (which include twelve hour shifts). This variable had a positive correlation to attitude (*r*=.2115, p<.025) and to sense of power (*r*=.2903, p<.004).

The greater the age of the individual the more positive the attitude (*r* =.2740, p<.005) and the greater sense of perceived power (*r*=.2284, p<.018), as measured by the NATMI and PKPCT. The higher the educational degree, the more positive the attitude (*r*=.3094, p<.002), the greater the ability to care (*r*=.4157, p<.000), and the greater sense of power (*r*=.3155, p<.002). Years of registered nurse experience was positively correlated with attitude (*r*=.4139, p<.000), ability to care (*r*=.2023, p<.031), and sense of power (*r*=.3173, p<.002). Years as an Air Force nurse had

very similar correlations, which included attitude ($r=.3414$, p<.001), ability to care ($r=.2383$, p<.014) and sense of power ($r=.3234$, p<.001). Years as a civilian registered nurse did not show significant correlations with any of the three study variables.

The positions of the nurses, ie charge or staff nurse, was positively correlated with attitude ($r=.3165$, p<.001) and sense of power ($r=.3145$, p<.002). The higher the position, the more positive the attitude and sense of power. There was no significant relationship between position and ability to care. Rank of the Air Force nurses showed positive correlations with all three study variables. Positive correlations between rank and attitude ($r=.2814$) were significant at the .004 level. Correlations between rank and ability to care ($r=.2326$) were significant at the .016 level. Rank and sense of power correlations ($r=.2903$) were significant at the .004 level. Refer to Appendix I for a complete matrix chart of all variables.

Table 6.

Demographic Variable Correlations

	Age	ED	YRSRN	YRSAFRN	POS	Shift	Rank
Attitude	.2740 p<.005	.3094 p<.002	.4139 p<.000	.3414 p<.001	.3165 p<.001	.2115 p<.025	.2814 p<.004
Power	.2284 p<.018	.3155 p<.002	.3173 p<.002	.3234 p<.001	.3145 p<.002	.3036 p<.002	.2903 p<.004
Caring	NOT SIG	.4157 p<.000	.2023 p<.031	.2383 p<.041	NOT SIG	NOT SIG	.2326 p<.016

NOTE: **ED** = Educational Level, **YRSRN** = Number of Years as a Registered Nurse
YRSAFRN = Number of Years as an Active Air Force Psychiatric/Mental Health Nurse
POS = Current Position, **Shift** = Usual Shift

ANALYSIS OF QUALITATIVE RESPONSES

Responses to the request that subjects describe any aspects of their environment which affects their ability to care for patients proved to be surprisingly candid and rich in qualitative data. Although this was not the main focus off the study, it was decided to analyze the responses in depth.

Of the 86 useable questionnaires returned, 44 (51 %) responded to this question. Some individuals responded with only a single comment, but many responded with several. There were a total of 157 separate comments identifying specific areas affecting how individuals perceive their ability to care. This question was purposely worded from a neutral position to allow for persons to identify those things they perceive as barriers as well as facilitators.

The actual comments were transcribed from the questionnaires and grouped by case numbers into the qualitative raw data (Appendix H). Each comment was then reviewed to identify a theme. As these themes were identified, they were grouped into concepts and labeled. Again, each comment was reviewed and coded based on which theme was considered the best fit. Finally, the items were tallied. The responses were divided into

two categories: barriers and facilitators toward caring. Comments identifying barriers were, by far, the most predominate with 127 (80.8 %). Thirty of the comments (19 %) identified characteristics which were perceived to be facilitative in nature. Of all of the 157 comments, including perceived barriers and facilitators, almost all were specific to the nurses' relationship with the system. Only 21 (13 %) of the comments focused on the nurses' relationship with the client.

Comments related to "barriers" were categorized into eight themes of perceptions. *Inadequate Administrative Support* was used to identify comments such as: "Insufficient staff," "Lack of investment in physical environment," "Lack of support from unit manager," "Psychiatric nurses transferred to medical units against their will when we had staff shortages," "Excessively long shifts (12 hour) and rotation to night shifts," "Lack of equipment," and "Length of time patients sometime remain on the ward." These are only a few of the 41 (26 %) comments that dealt with this theme. Many comments were specific to short staff, twelve hour rotating shifts, supplies, and administrative support issues.

The next largest theme, *Hierarchical Authority*, included comments such as: "Repeated changes in policy," Interventions by nurses are discounted and other treatment modalities are given credit for patients'

progress," "Air Force mental health nursing is 20 years behind civilian jobs,"
"I find the military system no different than any bureaucratic system,"
"Physician facilitated staff splitting," "Doctors who ignore nurses' input," and
"We have a doctor who has a degree in enabling and we feel powerless and
frustrated to change it." This authority theme focuses on the control issues
of a military system, on one hand, and the doctor control over nursing on
the other. Twenty-six comments (16.5 %) identified this theme.

Inadequate Emotional Support was the theme used to label responses
dealing with interactions of peers on the unit and emotional needs of the
nurses. Such comments as: "Lack of professional grooming and pats on the
back by supervisors and peers results in less than adequate patient care,"
Lack of staff motivation and investment," "Environment is angry and hostile
with the focus on the schedule and not on the patients," "Some nurses are
self-absorbed, self-righteous, resistive to any feedback," and "Nurses bitch
and complain about what they don't have and about one another."

Some of the statements took on themes that could be called
"Impoverished" in the *Modeling and Role-Modeling* theory. I labelled this
theme *Overwhelmed*. Comments such as: "My last psychiatric assignment,"
"I can't wait to leave the system," "There is little time left to get involved
with patients," "All staff feel tired and irritable," "I'm getting out of the Air

Force or into AF OR nursing. I guess I'm burned out," and "Disruption in (nurses) circadian rhythm creates for poor continuity in patient care." There were 12 (7.6 %) responses related to this theme.

Role Confusion was the theme identified in those areas in which nurses perceived feeling they were pulled in too many directions. There were needs to not only care for patients, but multiple administrative duties. "Administrative duties take away time from the unit and patients," "Administrative duties do not allow me time to be involved with patient care," and "Staff has multiple roles; we are not only nurses or technicians, we are also QA monitors, standards committee members, etc., etc.. These roles, while important, also place demands on our time and detract from patient care." Other role confusion issues were found when nursing goals conflicted with the institution goals, ie., "In the acute care setting, the focus is on diagnosis and disposition and not on treatment outcomes or resolution," "Any therapy that produces needed change is a bonus but not the actual goal as seen in the mission statement for the unit," "I am also confused at times of what our mission is: to treat? to evaluate? or to dispose or dump?." and related to a nurses potential and educational level "Despite my advanced degree, I am working as a staff nurse. With this

degree, I could work in the clinic with prescriptive privileges, as a clinical nurse specialist, or many other areas."

A perceived lack of value was another theme identified among the comments and has been labelled *Devaluation*. Some comments which reflect this theme are as follows: "There are no 0-6 slots designated for psychiatric nurses as there are for other specialties, as well as med/surg," "The Air Force does not legitimize the specialty of mental health nursing as they do other specialties," "People avoid us like the plague," "When people can stop calling where we work the 'Mental Ward' or 'Loony Bin,' we and our patients will have a lot more options and understanding about mental health," "Lack of being taken seriously and being viewed by physicians and supervisors as the experienced, well educated psychiatric nurse," and "Mental health nursing is viewed as much less important than med/surg, ER, OB/Gyn, or other 'true' nursing units. Eleven (7 %) of the comments reflected this theme.

Powerlessness was the last theme identified in the barrier category. This theme took on a wide range of topics from psychiatric nursing, the military, and patient care issues. Some of these include, "Change is slow or non-existent." "Too many people with 'problems' and high rank coming into the Air Force." "This questionnaire I didn't get to complete because of the

busy work load," "Before this, we dictated/told patients what we would do for them and what they needed to change," "Short hospital stays; the unit is crisis oriented," and "Nurses are struggling to gain a more active role in the community." There were 18 (11.4 %) comments in this category.

Facilitators, which were identified as affecting the ability of the nurses to care included eight themes. The first of these, *Valuing*, included comments such as: "When you start listening to the patients, they tell you what they need," "Staff works closely with a psychiatrist and psychologist and is involved in all patient decisions, "I feel patients receive excellent care," and "I have worked with nurses who were very dynamic, ma ing nursing fun and valuable." There were a total of ten (6.3 %) of this category of comments.

Nurturing was the concept attached to the following type of comments: "These nurses placed the clients first and foremost in their activities," "Total Quality Management (TQM) and the interest of the chief nurse in improving patient care are positive influences," and "There are positive effects on the patients with teaching classes, increasing coping skills, and 1:1 counseling." There were a total of seven (4.4 %) of these nurturing comments.

It was not surprising that some comments revealed the importance of feeling decisions are the correct ones dealing with patient care and peer relationships. Four (2.5 %) of the comments were given the concept name of *Validating*. Comments supporting this theme include: "We quit treating the patients with 'potential for' and used our nursing assessment skills in determining (along with the patient) how much restriction they require," "All planning is done together with the patient; input from the patient is important," "New nurses with new ideas," and "These nurses respect each other as professionals and were receptive to teaching one another and learning from one another."

Autonomy was the concept name given comments addressing positive decision-making ability. Four comments (2.5 %) were determined to fit into this category. "There is a lot of creativity and autonomy allowed with strong TQM support from management." "I have the authority to make decisions on my unit," "A positive is that we are empowered to look at alternative delivery models," and "The opportunity to be innovative is present."

Three comments (1.9 %) stated very positive aspects of their ability to care for patients. These include: "Compared to other units in the Air Force, our staffing is excellent (that is in numbers)," "My vision is to see a

cohesive, high functioning staff that will indirectly improve quality of patient care," and "Needs for positive support and encouragement of supervisors and superiors within the department of nursing." This theme was identified as *Support*.

The last theme in the facilitator category was identified as *Flexibility*. Two responses (1.2 %) fit in this grouping: "I do what I can to bring my educational experience and background in as much as possible," and "The ability to adapt, to be flexible, to adjust to varying situations have been keys to my success." See table 7 for a summary of the qualitative results. Refer to Appendix J for raw data on responses.

Table 7.

Qualitative Data Summary

Barriers	Number of Responses	Percent	Facilitators	Number of Responses	Percent
Inadequate Administrative Support	41	26.1 %	Valuing	10	6.3 %
Hierarchical Authority	26	16.5 %	Nurturing	7	4.4 %
Inadequate Emotional Support	13	8.3 %	Validating	4	2.5 %
Powerlessness	13	8.3 %	Autonomy	4	2.5 %
Overwhelmed	13	8.3 %	Support	3	1.9 %
Role Confusion	11	7.0 %	Flexibility	2	1.2 %
Devaluation	11	7.0 %			
Total	127	81 %	Total	30	19 %

Note: Some subjects stated more than one response.

CHAPTER V

DISCUSSION

Chapter V is presented in six sections. The first section, <u>Relation of Attitudes with Nurses' Ability to Care</u>, relates responses of subjects to their perceived attitudes and how this relates to their ability to care for their patients. The second section, <u>Relationship of Attitudes Toward Their Patients and Nurses' Perceived Power</u>, addresses how the responses of the nurses to attitudes toward their patients and their perceived power relates to the concept of *Affiliated-Individuation* within the nursing theory of *Modeling and Role-Modeling* (Erickson, Tomlin, & Swain, 1990) around which this study was based. The third section, <u>Relationship of Power with Nurses' Ability to Care</u>, examines responses by nurses in relation to their "system" focus versus "patient" focus, and how a nurses' perceived power in their work environment could affect their ability to care for their patients. The fourth section, <u>Relationship of Attitudes, Power, and Caring</u>, describes models developed based on this study using the study variables. These models compare the "system" oriented caring ability of the nurse with the

"client" oriented caring ability of the nurse. The fifth section, Limitations, addresses limitations of this study. In summary, Recommendations and Implications for nursing practice are discussed.

RELATIONSHIP OF ATTITUDES WITH NURSES' ABILITY TO CARE

Findings of this study indicates that attitudes of Air Force psychiatric nurses toward their patients does play a role in a nurses ability to care for these patients, as reflected in a moderate correlation ($r = .3081$, $p < .01$) between attitudes and caring. Some of the qualitative data suggests that role confusion may be a contributing factor to this relationship when the policies of the military system, ie. "evaluation and disposition," are in conflict with the role of nursing to assist the client toward an adaptive and holistic state of health. Erickson, Tomlin, and Swain (1990) identify five aims of nursing interventions: (1) building trust; (2) promoting the client's positive orientation; (3) promoting the client's control; (4) affirming and promoting the client's strengths; and (5) setting mutual goals that are health directed. It is the fifth aim of "setting mutual goals that are health directed" (p. 171) that can conflict with the military's focus on evaluation of an individual's fitness for duty and determination of their retainability. Those not retained are discharged or retired from the military. The nurse is challenged to

separate the five aims of nursing interventions within the nursing model of client care from the medical model system they may work in.

The 157 comments by nurses from this study were heavily focused on the system and the issues associated with surviving within that system. It is likely that individuals involved so deeply within their environment would assimilate attributes of the system, especially attitudes. This is not exclusive to the military, but also society in general. Seventy-eight nurses (93 %) in this study identified that they believe persons who are labelled with mental illness are discriminated against in their work environment. The military openly advertises that individuals with mental illness are often not an acceptable "risk" to be retained on active duty. Fifty percent (N=43) identified that the military environment is less accepting of mental illness than general society

While some individuals are successfully treated through outpatient clinics and returned to their jobs, those individuals which are hospitalized are considered more severe cases, and the hospitalization is seen as the first stop "out the door." Air Force mental health nurses on hospital units are often exposed to "worst case scenarios" on a daily basis. That may have a significant effect on these nurses' attitudes. Forty-five percent of the nurses (N=39) identified that they need to see positive outcomes to maintain their

motivation. Forty-one (47.7 %) agreed or strongly agreed that their patients lose their jobs because of mental illness. One way to promote positive attitudes toward the patients would be to allow nurses to experience more positive scenarios.

Air Force mental health nurses could benefit and increase their ability to care for patients by experiencing the positive outcomes which are observed in the outpatient mental health clinics. Many Air Force psychiatric nurses are highly qualified to work in Air Force outpatient mental health clinics. Of the 86 nurses responding to the survey, 23.3 % (N=20) had MSN degrees. One comment addressing this issue states that "My ability to care for patients has to do with the Air Force itself. Despite my advanced degree, I am working as a staff nurse. With my degree, I could work in a clinic with prescriptive privileges as a clinical nurse specialist, or many other areas." Opportunities for advancement within a nurse's field can be a motivating force, not just to improve in skills, but to influence a more positive attitude toward the perception of mental illness by nurses employed in that specialty area.

Forty-six nurses (54.1 %) did not believe that psychiatric nursing was valued. Several of the qualitative data comments addressed a lack of support for psychiatric nursing from upper management. This extended

even to promotion opportunities, ie., "There are no 0-6 (Colonel) slots designated for psychiatric nurses as there are for other specialties (in nursing) including medical/surgical (nursing)."

In conclusion, this study clearly establishes the existence of a statistically significant relationship between nurses' attitudes toward their patients and the ensuing impact on these nurses' ability to care for their clients. Those individuals who have negative attitudes toward patients on the ward, or their illness, may very well have difficulty establishing a caring relationship.

RELATIONSHIP OF ATTITUDES TOWARD THEIR PATIENTS AND NURSES' PERCEIVED POWER

Findings form this study indicate that there is a moderate correlation ($r=.5159$, $p<.01$) between Air Force mental health nurses' attitudes toward their patients and their sense of power within their work environment related to awareness, choices, freedom to act intentionally, and involvement in creating change. While this correlation is not in itself conclusive, it could suggests that perceived power within the system can promote a positive orientation of attitudes toward patients within the nurses' care. Specifically,

nurses experiencing power within their own environment may promote orientation of self-worth, hope, and strength in their patients.

Looking at this relationship from a *Modeling and Role-Modeling* theory (Erickson, Tomlin, & Swain, 1990) perspective, the degree of power the nurse experiences from the work environment could be compared to the concept of *Affiliated-Individuation*. In this concept, there is a need of the individual (here it would be the nurse) to be dependent on support systems (here it would be the organizational system) while simultaneously maintaining independence from the support system. There is a need to perceive freedom and acceptance in both states. The power of the nurse identifies the need to belong to the system without being controlled by it.

Modeling and Role-Modeling is so named because of the importance placed on the nurse's ability "model" the clients world, or approach the client form his/her world view. Modeling the client's world is influenced by the ability of the nurse to have positive attitudes toward the client and accept the client unconditionally. After establishing a relationship with the client, the next phase is to "role-model" a healthier world for the client. The ability of the nurse to model this healthier world requires the nurse to draw from healthy experiences in the nurse's own environment. If the nurse perceives

frustration and lack of power within the nurse's own environment, this may be difficult to accomplish.

This study reflects the need to consider the nurses' perceived sense of power within their environment and their attitudes toward their patients in relation to how patient/nurse relationships can be influenced.

RELATIONSHIP OF POWER WITH NURSES' ABILITY TO CARE

Findings of this study indicate that the perceived power of the Air Force mental health nurse plays a role in the nurse's ability to care for their patients as reflected in a moderate correlation ($r=.5532$, $p<.01$). The need to perceive a sense of power within the work environment may be necessary for the purpose of making decisions and feeling a sense of control over nursing practice. As an example, if a nurse is able to choose the topic of the didactic group which the nurse believes to be most appropriate to address specific patients' needs, the nurse may be a more effective group leader, thereby, promoting a more effective ability to care. Participating knowingly in change and decision making is the basis of the measurement tool, PKPCT, used in this study.

Psychiatric hospital units are unique in that the discussions a nurse has with a patient, or the time spent with a patient, can be considered a medical decision. On any other hospital unit, this decision would be considered specific to nursing. In these situations, nursing can be dictated by other disciplines. One would ask what interventions on a psychiatric unit are specific to nursing? Nursing can be very restricted or free in its decision-making abilities depending on the support from physicians and administrators. The word "dependent" is critical to this discussion.

Within the military setting, the data indicates that nurses are dependent on the system to perform nursing. The nurses' primary relationship is with the system rather than with the patient. When asked what aspects of their environment affect their ability to care, I expected that nurses would identify more issues associated specifically with patients, ie., patients' specific issues related to, and consequences associated with the military, such as patients' forced separation from service, etc.. However, most comments, related to ability to care for patients, were specific to barriers associated with the actual system itself.

RELATIONSHIP OF ATTITUDES, POWER AND CARING

From the system perspective, nurses must first find ways to deal with these barriers endemic to the system if a patient centered focus is to be taken. A model (Figure 1) has been developed which incorporates the findings of this study into a larger context. This model depicts a *System Orientation* focus of the nurses' ability to care for the patient.

Attitudes

Nurses' attitudes are influenced by values and beliefs. The nurse approaches the relationship with attitudes resulting from values, beliefs and past experiences. Patients attitudes *resulting from values and beliefs are* seldom considered, as reflected from the qualitative data of this study.

Barriers and Power

In a linear approach, nurses first make contact with various barriers within the system. These barriers are frequently controlled by the system in which the nurse is providing patient care. The barriers, identified by the qualitative data in this study, include the following concepts: overwhelmed, powerlessness, devaluation, inadequate administrative support, role confusion, inadequate emotional support, and hierarchical authority.

The nurses' perceived level of power, high or low, may be directly related to these barriers. When these barriers are low, the nurse perceives a greater sense of power and autonomy within the system. When these barriers are high, the nurse perceives less power and lack of autonomy within the system. The degree of power directly correlates to the ability to care ($r = .5532$, $p < .01$).

Nurse/Patient Relationship

The nurse's ability to care corresponds to the relationship the nurse establishes with the patient. This model depicts the nurse caught in the middle between the patient and the system, often pulled between them. The patient is seen as helpless, needy, and vulnerable, while the system is viewed as that having power, control, authority, and dominance. In this situation, especially when barriers are high, the nurse can be preoccupied with system minimizing the patient and nurse relationship. Again, looking at Figure 1, nurses find themselves caught between the patients and the institutional system. The nurse/patient relationship is dependent on the institutional system. In this model, the patient is viewed as helpless and vulnerable, as many military psychiatric patients are within the military system.

The nurses' attitudes, perceived barriers, and power within the system directly impact their ability to establish a relationship with the patients on the unit.

Patient Outcomes

With the system orientation model, the patient outcomes are evaluated from the medical model. From the qualitative data, "I am confused at times of what is our mission, to treat? to evaluate? or to dispose or dump?," implies that evaluation and disposition may be a focus, regardless of the patient's ability to adapt toward health and holism. Comments reflect frustration on the part of the nurse, both on the individual and professional level.

Last, what is the effect on the patient who depends on the nurse/ system relationship? Within the military psychiatric system, measurement of patient outcomes can mean different things. There is no rule which states that medical goals and nursing goals must be the same. For example, a medical goal may be to successfully evaluate and medically diagnose a patient with a DSM-III-R diagnosis for the purpose of sending a patient to a medical evaluation board, to a physical evaluation board, and finally to discharge the patient with some type of financial compensation. It can be easy for nurses to get caught up in this systematic approach to patient care

through the influence of multiple staff meetings with the physicians which are often client illness focused. Patients often have little control in this process and may feel justifiably threatened both personally and professionally.

Future studies may want to examine relationships between an individual's perceived power within the work environment and the identified barriers that nurses experience which affect their ability to care. Qualitative data which describes facilitative factors affecting the nurses ability to care tended to be more patient oriented and less system oriented. Perhaps this means that when nurses stop "fighting" the system, they may have more time for the patients. This is another area of nursing which could benefit from future study.

FIGURE 1.
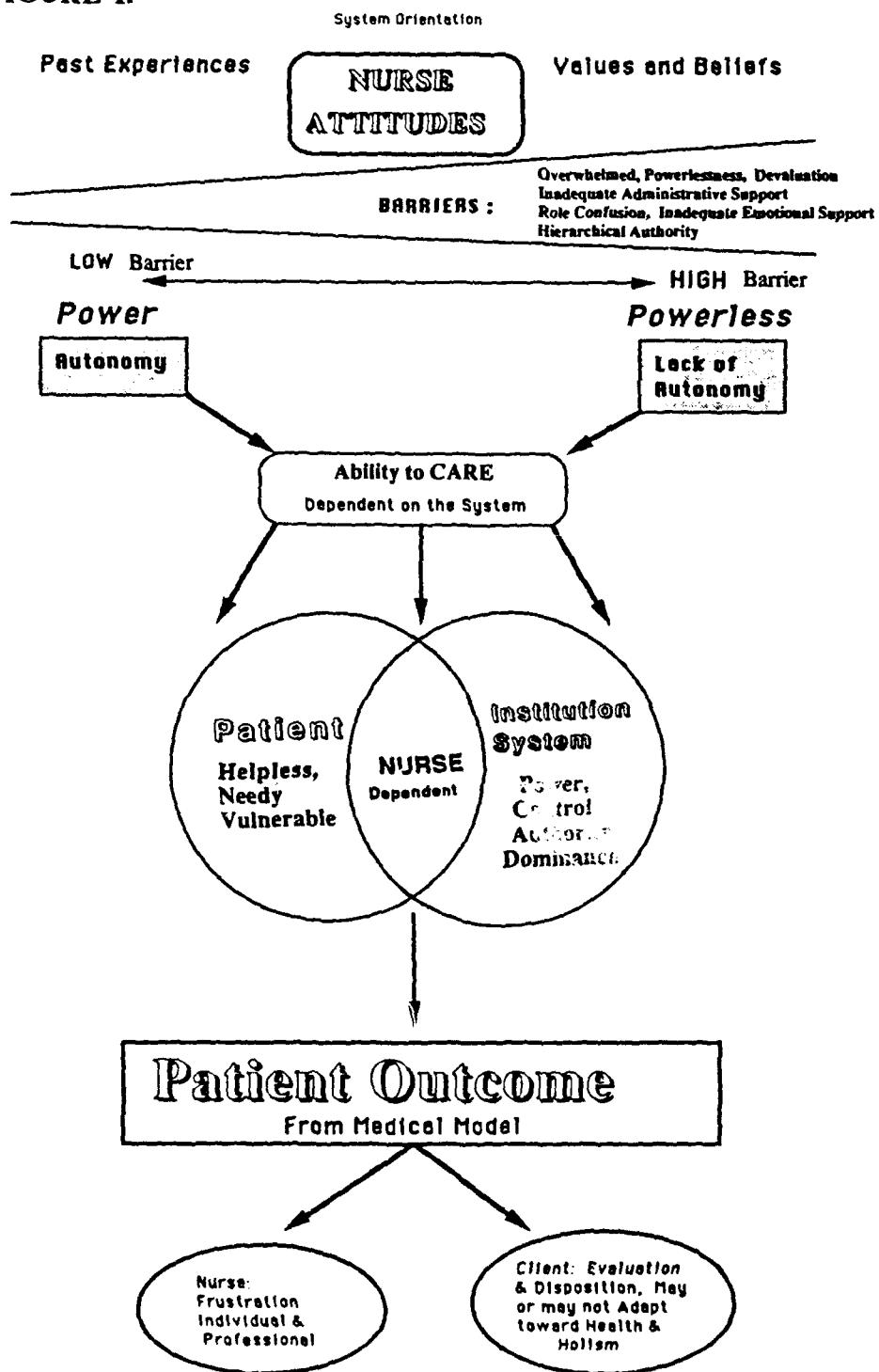
Nursing goals, according to the nursing theory of *Modeling and Role Modeling*, encourage nurses to focus specifically on those areas for which the nurse has control. In order to accomplish this, the main focus must be on the relationship between the nurse and the patient independent of the system. A second model is now proposed that depicts an alternative approach and outcome (refer to Figure 2). This *Client Orientation* model depicts an interactive process between the client and the nurse in the formation of attitudes.

Attitudes

Each person approaches the relationship with their own values, beliefs, and experiences. The client is identified as a "client" and not a "patient," because the term patient represents a dependent individual in need of being cared for. The term "client" represents a more equal partner in the relationship. The client in this model has an inherent desire for self-potential and growth. The nurse approaches the relationship with the ability to care about and nurture the client. The nurse's successful affiliated-individuation (Erickson, Tomlin, & Swain, 1990) from the system, can best be described as the nurses ability to remain part of their system while at the same time maintaining independence from the system.

Barriers and Power

The nurse still brings to the relationship attitudes and encounters barriers. These barriers, however, are those for which the nurse has control, unlike those in Figure 1. The nurse can choose to establish an interactive process which is the first step in establishing a relationship with a client. These barriers include the ability of the nurse to: (1) care; (2) acknowledge the client from the client's world view; (3) focus on the client's strengths and health; (4) unconditional acceptance of the client; (5) assess the client's unmet needs; and (6) maintain an independent relationship with the client.

This barrier influences the interactive interpersonal process with the client and the amount of power the nurse perceives within the nurse/client relationship. The perceived power of the nurse is measured more by the establishment of the interpersonal process with the client than as with the previous model which depended on level of barriers.

Nurse/Client Relationship

The nurse/client relationship depicted in this model is independent of the system. The client is view as an individual with perceived needs, past experiences, having beliefs, inherently good, and wants to be healthy. The nurse is an individual who is caring, nurturing, and can approach the client

from the client's world. The nurse has values and beliefs which are brought into the relationship.

Client Outcomes

A nursing goal for the client is adaptation toward health and holism, through building trust, promotion of client control, affirmation of the client's strengths, and the setting of mutual goals (Erickson, Tomlin, & Swain, 1990). These goals may be very different from the medical goal or have little to do with the medical evaluation process. Client outcomes measured from a nursing model focus on both the client and the nurse. Each person in this relationship takes something away from the interaction. The client achieves adaptation toward health and holism. The nurse should also have a personal goal in this relationship with the client and work toward growth both individually and professionally.

While the model in Figure 2 may be an ideal view of nursing, especially on an Air Force psychiatric hospital unit, it can help to focus nurses on the positive aspects and power of nursing. When nurses can focus their energy on the power of nursing, instead of the power within the system where they work, it may positively influence the nurses ability to care.

FIGURE 2.
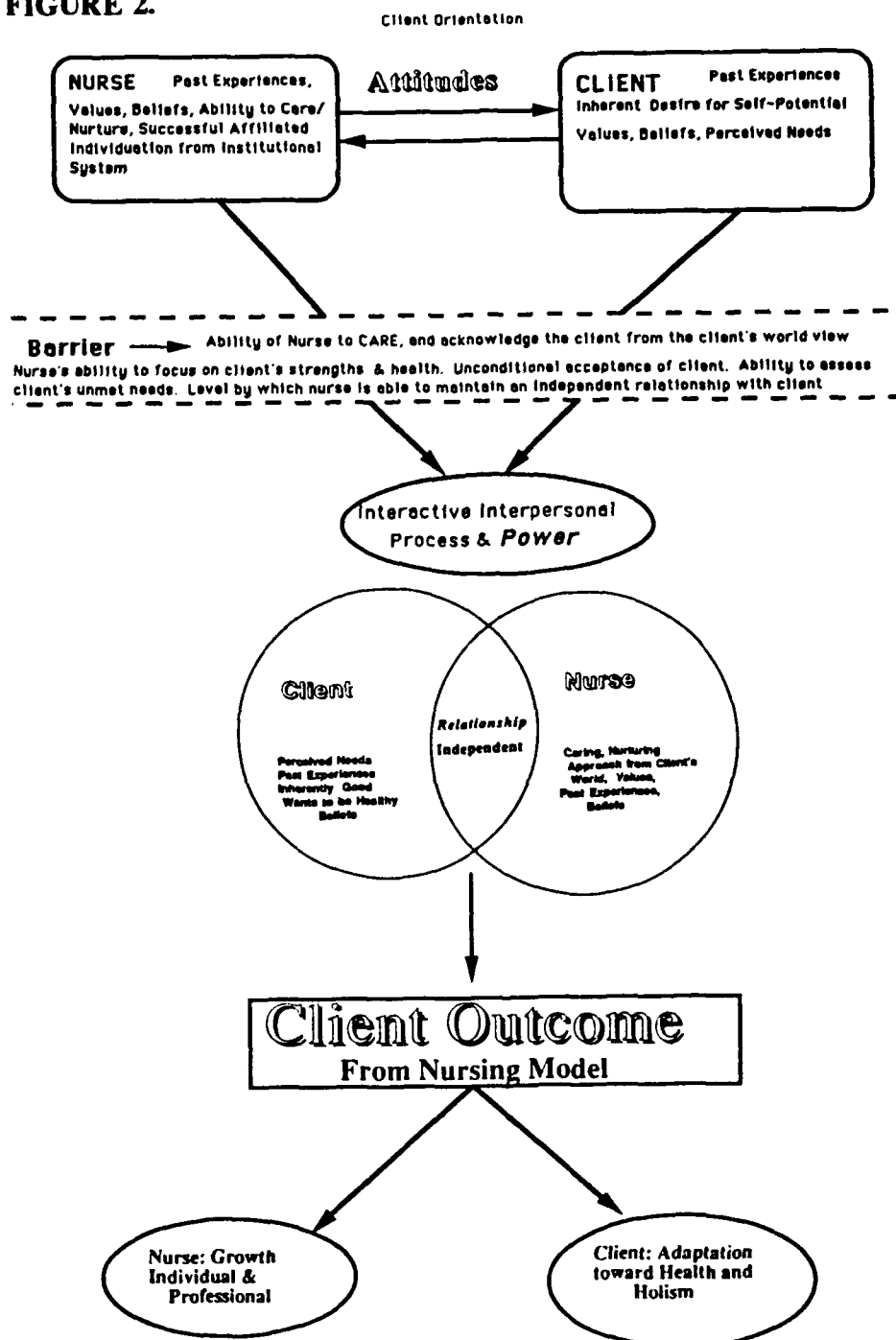
LIMITATIONS

This study was done with a very specific population of active duty Air Force mental health nurses; they each have been an Air Force mental health nurse for at least one year. Findings from this study cannot necessarily be generalized to other psychiatric nursing populations and therefore, recommendations for further study include repeating this study using other groups of psychiatric nurses from various settings. If other settings are examined, the NATMI would require some modifications on those instrument items specific to the military environment.

In all, ninety-five (65 %) out of the 144 Air Force mental health nurses responded to the survey, including those not meeting the one year criteria. Even with this positive response rate, it is important to consider that there may be extraneous variables not considered which could have biased the results. The amount of time required to complete the survey may have been a limiting factor, especially since so many individuals described staffing problems as a concern regarding their ability to care for patients. When examining question #129, the small number of positive facilitative remarks could be attributed to the fact that individuals who are content with their environment did not pursue the question, while those who perceived problems were more motivated to take the time to respond.

RECOMMENDATIONS AND IMPLICATIONS

Though findings cannot be generalized to all mental health nurses on in-patient settings, it should well represent Air Force mental health nurses. The results and conclusions may even be similar for similar studies of military mental health nurses. Attitudes and perceived power can play a large role in these nurses' ability to care for patients, as well as grow as individuals within their profession. Administrators may want to consider staff interventions designed to improve attitudes, such as rotations to clinics where positive client outcomes can be experienced. Nursing leaders within the hospital environment can increase the mental health nurses' sense of power within the organization. This can be done by showing they are valued by taking a personal, active interest in unit activities, encouraging the same career opportunities presented in other specialty areas, and promoting and supporting nurses' decision-making abilities to manage the day-to-day activities of their unit.

APPENDIX A

CONSENT FORM

A Study of Perceptions and Values of Air Force Mental Health Nurses

Toward Their Job and the Patients They Care For

Dear Air Force Nurse Colleague,

You are invited to participate in a study of Air Force psychiatric/mental health nurses. My name is Capt Mary Higgins and I am an Air Force Institute of Technology (AFIT) graduate student at the University of Texas at Austin, School of Nursing. This study is being done as part of my master's thesis requirement. I hope to learn about perceptions and values of Air Force mental health nurses toward mental illness and the patients they care for, as well certain perceptions about their job. You were selected as a possible participant in this study because of your experience as a psychiatric/mental health nurse within the Air Force. You will be one of 150 subjects, all active duty 9726's, chosen to participate in this study.

If you decide to participate, I would ask that you complete the enclosed survey packet. It will take you approximately 20-30 minutes to complete the questionnaire. Except for time inconvenience, there are no identified risks to participants. Please return these surveys to me in the enclosed envelope upon completion. There is no monetary compensation for participating in the study. Benefits include the opportunity for participants to examine their attitudes toward their job and the patients in their care.

Any information obtained in connection with this study and that can be identified with you will remain confidential. The questionnaire has an code number for mailing purposes only. This is so I can check your name off the mailing list when your questionnaire is returned. Your name will never be connected with responses on the questionnaire, no identifying information will be reported, and all identifying information will be destroyed at the end of data collection. Access to participants' names and code numbers will be limited to myself and my thesis supervisor, Dr. Carolyn Kinney. Data will be reported as group data only with no reference to individual subjects.

You are under no obligation to participate in the study. Your completing and returning the questionnaire will be taken as evidence of your willingness to participate and your consent to have the information used for the purposes of the study. Your participation in this study will not jeopardize your association or relationship with the U.S. Air Force or the University of Texas at Austin School of Nursing.

I know your time is valuable. Your cooperation is greatly appreciated. When you complete the questionnaire, please return it in the enclosed stamped envelope by (date - 2 weeks). If you have any questions, please call me or my supervising professor, Carolyn Kinney, PhD, RN, at the telephone number listed below. You may retain the cover letter explaining the nature of your participation. Again, thank you very much.

Sincerely,

Mary M. Higgins, Capt, USAF, NC
University of Texas at Austin, School of Nursing
1700 Red River
Austin, TX 78701-1499
(512) 471-7311 or (512) 629-7374

APPENDIX B

REMINDER POSTCARD

Dear Air Force Nurse Collegue,

I recently sent you a questionnaire on perceptions and values of Air Force mental health nurses' toward mental illness, the patients they care for, and their job. You are very important to the success of this study.

If you have not done so, would you please take time from your busy schedule to complete and return the survey ?

Thank you in advance for your help with this study.

Mary M. Higgins, Capt, USAF, NC

Post Card

Did You Forget ?
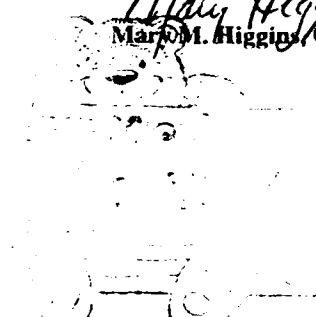
APPENDIX C

NURSES' ATTITUDES TOWARD MENTAL ILLNESS QUESTIONNAIRE (NATMI)

A Survey of Perceptions and Values of Nurses Toward Their Job and Patients in their Care

Please answer the following questions with an "X" in the appropriate column. Answer as best as it applies to your perception of your military work environment.

(SA) Strongly Agree, (A) Agree, (?) Undecided, (D) Disagree, (SD) Strongly Disagree

	SA	A	?	D	SD
1. Mental illness is viewed by nurses as no different than a medical illness.					
2. In general, I feel a sense of hope for the mentally ill patients I work with.					
3. Psychiatric patients are valued by society.					
4. Psychiatry is putting "Band-Aids" on the cancer of society.					
5. Psychiatric nursing interventions are valued little by society.					
6. Patients who are labelled with a mental illness are not discriminated in their work environment.					
7. Stigmatization of mental illness is isolating and dehumanizing.					
8. I am personally afraid of mental illness.					
9. The military environment is less accepting of mental illness than general society.					
10. Most patients I care for on the psychiatric unit eventually lose their jobs because of mental illness (including personality disorders).					
11. I often feel a sense of despair for the mentally ill patients I work with.					
12. Control and domination is not the focus of patient treatment on the unit.					
13. A least restrictive environment philosophy is practiced on my unit.					
14. Perceived lack of control over nursing on the psychiatric unit makes it difficult to trust my own perceptions.					
15. Psychiatric nursing represents a highly valued occupation.					

(SA) Strongly Agree, (A) Agree, (?) Undecided, (D) Disagree, (SD) Strongly Disagree

	SA	A	?	D	SD
16. Psychiatric patients have little personal freedom.					
17. Negative stereotyping and labeling of psychiatric patients is not a current problem in modern society.					
18. Mental Health treatment is focused on compassion and the needs of the patient.					
19. Issues associated with mental illness are too overwhelming to deal with.					
20. When patients improve, it is generally attributed to medication and not to the milieu.					
21. Persons with mental illness are respected as individuals.					
22. I do not need to see positive outcomes to maintain motivation.					
23. What I do in nursing is lost within the psychiatric system as a whole.					
24. Expectations and goals for psychiatric patients should be small and limited.					
25. Improvement in a patient's condition is seldom associated with nursing interventions.					
26. Psychiatric hospitalization provides for a chemical "time out" in a physically different space.					
27. Mental health treatment is rigid and is focused on control and rules of the institution.					
28. Individuals with mental illness can expect to have problems with mental illness of varying degrees for the rest of their lives.					
29. I enjoy interacting with the patients on the unit.					
30. When patients say "The military is out to get me" it is probably not true.					

APPENDIX D

CARING ABILITY INVENTORY (CAI)

Please read each of the following statements and decide how well it reflects your thoughts and feelings about other people in your work environment. There is no right or wrong answer. Using the response scale from 1 to 7, circle the degree to which you agree or disagree with each statement.

1 2 3 4 5 6 7
strongly   strongly
disagree   agree

	Strongly Disagree					Strongly Agree	
	1	2	3	4	5	6	7
31. I believe that learning takes time.	1	2	3	4	5	6	7
32. Today is filled with opportunities.	1	2	3	4	5	6	7
33. I usually say what I mean to others.	1	2	3	4	5	6	7
34. There is very little I can do for a person who is helpless.	1	2	3	4	5	6	7
35. I can see the need for change in myself.	1	2	3	4	5	6	7
36. I am able to like people even if they don't like me.	1	2	3	4	5	6	7
37. I understand people easily.	1	2	3	4	5	6	7
38. I have seen enough in this world for what I need to know.	1	2	3	4	5	6	7
39. I make the time to get to know other people.	1	2	3	4	5	6	7
40. Sometimes I like to be involved and sometimes I do not like to be involved.	1	2	3	4	5	6	7
41. There is nothing I can do to make life better.	1	2	3	4	5	6	7
42. I feel uneasy knowing that the other person depends on me.	1	2	3	4	5	6	7
43. I do not like to go out of my way to help other people.	1	2	3	4	5	6	7
44. In dealing with people, it is difficult to let my feelings show.	1	2	3	4	5	6	7
45. It does not matter what I say, as long as I do the right thing.	1	2	3	4	5	6	7
46. I find it difficult to understand how the other person feels if I have not had similar experiences.	1	2	3	4	5	6	7
47. I admire people who are calm, composed, and patient.	1	2	3	4	5	6	7
48. I believe it is important to accept and respect the attitudes and feelings of others.	1	2	3	4	5	6	7
49. People can count on me to do what I say I will.	1	2	3	4	5	6	7
50. I believe there is room for improvement.	1	2	3	4	5	6	7
51. Good friends look out for each other.	1	2	3	4	5	6	7
52. I find meaning in every situation.	1	2	3	4	5	6	7
53. I am afraid to "let go" of those I care for because I am afraid of what might happen to them.	1	2	3	4	5	6	7
54. I like to offer encouragement to people.	1	2	3	4	5	6	7
55. I do not like to make commitments beyond the present.	1	2	3	4	5	6	7
56. I really like myself.	1	2	3	4	5	6	7
57. I see strengths and weaknesses (limitations) in each individual.	1	2	3	4	5	6	7
58. New experiences are usually frightening to me.	1	2	3	4	5	6	7
59. I am afraid to be open and let others see who I am.	1	2	3	4	5	6	7
60. I accept people just the way they are.	1	2	3	4	5	6	7
61. When I care for someone else, I do not have to hide my feelings.	1	2	3	4	5	6	7
62. I do not like to ask for help.	1	2	3	4	5	6	7
63. I can express my feelings to people in a warm and caring way.	1	2	3	4	5	6	7
64. I like talking with people.	1	2	3	4	5	6	7
65. I regard myself as sincere in my relationships with others.	1	2	3	4	5	6	7
66. People need space (room, privacy) to think and feel.	1	2	3	4	5	6	7
67. I can be approached by people at any time.	1	2	3	4	5	6	7

APPENDIX E

POWER AS KNOWING PARTICIPATION IN CHANGE TOOL (PKPCT)

Check the spaces below that best reflect your feelings about your AWARENESS related to your job. Make one check for each bipolar set of words.

MY AWARENESS IS

68.	profound	___:___:___:___:___:___:___	superficial
69.	avoiding	___:___:___:___:___:___:___	seeking
70.	valuable	___:___:___:___:___:___:___	worthless
71.	unintentional	___:___:___:___:___:___:___	intentional
72.	timid	___:___:___:___:___:___:___	assertive
73.	leading	___:___:___:___:___:___:___	following
74.	chaotic	___:___:___:___:___:___:___	orderly
75.	expanding	___:___:___:___:___:___:___	shrinking
76.	pleasant	___:___:___:___:___:___:___	unpleasant
77.	uninformed	___:___:___:___:___:___:___	informed
78.	free	___:___:___:___:___:___:___	constrained
79.	unimportant	___:___:___:___:___:___:___	important
80.	unpleasant	___:___:___:___:___:___:___	pleasant

Check the spaces below which best reflect your feelings about your CHOICES related to your job. Make one check for each bipolar set of words.

MY CHOICES ARE

81.	shrinking	___:___:___:___:___:___:___	expanding
82.	seeking	___:___:___:___:___:___:___	avoiding
83.	assertive	___:___:___:___:___:___:___	timid
84.	important	___:___:___:___:___:___:___	unimportant
85.	orderly	___:___:___:___:___:___:___	chaotic
86.	intentional	___:___:___:___:___:___:___	unintentional
87.	unpleasant	___:___:___:___:___:___:___	pleasant
88.	constrained	___:___:___:___:___:___:___	free
89.	worthless	___:___:___:___:___:___:___	valuable
90.	following	___:___:___:___:___:___:___	leading
91.	superficial	___:___:___:___:___:___:___	profound
92.	informed	___:___:___:___:___:___:___	uninformed
93.	timid	___:___:___:___:___:___:___	assertive

Check the spaces below that reflect your feelings about your FREEDOM TO
ACT INTENTIONALLY in your job. Make one check for each bipolar set of words.

MY FREEDOM TO ACT INTENTIONALLY IS

94.	timid	___ :	___ :	___ :	___ :	___ :	___ :	___ assertive
95.	uninformed	___ :	___ :	___ :	___ :	___ :	___ :	___ informed
96.	leading	___ :	___ :	___ :	___ :	___ :	___ :	___ following
97.	profound	___ :	___ :	___ :	___ :	___ :	___ :	___ superficial
98.	expanding	___ :	___ :	___ :	___ :	___ :	___ :	___ shrinking
99.	unimportant	___ :	___ :	___ :	___ :	___ :	___ :	___ important
100.	valuable	___ :	___ :	___ :	___ :	___ :	___ :	___ worthless
101.	chaotic	___ :	___ :	___ :	___ :	___ :	___ :	___ orderly
102.	avoiding	___ :	___ :	___ :	___ :	___ :	___ :	___ seeking
103.	free	___ :	___ :	___ :	___ :	___ :	___ :	___ constrained
104.	unintentional	___ :	___ :	___ :	___ :	___ :	___ :	___ intentional
105.	pleasant	___ :	___ :	___ :	___ :	___ :	___ :	___ unpleasant
106.	orderly	___ :	___ :	___ :	___ :	___ :	___ :	___ chaotic

Check the spaces below that best reflect your feelings about the INVOLVEMENT IN
CREATING CHANGE within your job. Make one check for each bipolar set of words.

MY INVOLVEMENT IN CREATING CHANGE IS

107.	unintentional	___ :	___ :	___ :	___ :	___ :	___ :	___ intentional
108.	expanding	___ :	___ :	___ :	___ :	___ :	___ :	___ shrinking
109.	profound	___ :	___ :	___ :	___ :	___ :	___ :	___ superficial
110.	chaotic	___ :	___ :	___ :	___ :	___ :	___ :	___ orderly
111.	free	___ :	___ :	___ :	___ :	___ :	___ :	___ constrained
112.	valuable	___ :	___ :	___ :	___ :	___ :	___ :	___ worthless
113.	uniformed	___ :	___ :	___ :	___ :	___ :	___ :	___ informed
114.	avoiding	___ :	___ :	___ :	___ :	___ :	___ :	___ seeking
115.	leading	___ :	___ :	___ :	___ :	___ :	___ :	___ following
116.	unimportant	___ :	___ :	___ :	___ :	___ :	___ :	___ important
117.	timid	___ :	___ :	___ :	___ :	___ :	___ :	___ assertive
118.	pleasant	___ :	___ :	___ :	___ :	___ :	___ :	___ unpleasant
119.	superficial	___ :	___ :	___ :	___ :	___ :	___ :	___ profound

APPENDIX F

BIOGRAPHICAL DATA QUESTIONNAIRE

Please check one statement to each items which applies to you.

120. SEX

( ) Male   ( ) Female

121. AGE

( ) 20-24   ( ) 25-29   ( ) 30-34   ( ) 35-39
( ) 40-44   ( ) 45-49   ( ) 50 and over

122. Educational Level

( ) BS other than nursing   ( ) BSN   ( ) MSN   ( ) MS other than nursing   ( ) doctoral

123. Number of Years as a Registered Nurse

( ) under 2   ( ) 2 - 5   ( ) 6 - 10   ( ) 11 - 15   ( ) 16 - 20
( ) over 20

124. Number of years as a civilian registered nurse in psychiatric nursing

( ) under 1   ( ) 1 - 3   ( ) 3 - 5   ( ) 6 - 10
( ) over 10

125. Number of Years as an active Air Force psychiatric/mental health nurse

          ( ) under 1   ( ) 1 - 3   ( ) 3 - 5
          ( ) 6 - 10   ( ) 11 - 15   ( ) 16 - 20   ( ) over 20

126. Current position

( ) staff nurse   ( ) assistant charge nurse
( ) charge nurse   ( ) coordinator   ( ) clinical specialist
( ) other _____(please fill in)

127. Usual Shift

          ( ) Days   ( ) Eves   ( ) Nights
          ( ) Rotate all   ( ) other_____

128. Rank

( ) 2 LT   ( ) 1LT   ( ) Capt   ( ) Maj
( ) Lt Col   ( ) Col

129. Please describe any aspects of your environment which affect your ability to care for patients. You may continue one the back side of this paper for your response.

THANK YOU FOR YOUR PARTICIPATION !

APPENDIX G

FREQUENCY CHARTS of VARIABLES

Nurses' Attitude Toward Mental Illness (NATMI) Frequency Scores

Value	Frequency	Percent	Valid Percent	Cum Percent
70.00	1	1.2	1.2	1.2
75.00	1	1.2	1.2	2.3
76.00	3	3.5	3.5	5.8
78.00	1	1.2	1.2	7.0
79.00	1	1.2	1.2	8.1
81.00	3	3.5	3.5	11.6
82.00	2	2.3	2.3	14.0
83.00	1	1.2	1.2	15.1
86.00	1	1.2	1.2	16.3
87.00	1	1.2	1.2	17.4
88.00	2	2.3	2.3	19.8
90.00	2	2.3	2.3	22.1
91.00	2	2.3	2.3	24.4
92.00	10	11.6	11.6	36.0
93.00	2	2.3	2.3	38.4
94.00	3	3.5	3.5	41.9
95.00	3	3.5	3.5	45.3
96.00	3	3.5	3.5	48.8
97.00	3	3.5	3.5	52.3
98.00	1	1.2	1.2	53.5
99.00	2	2.3	2.3	55.8
101.00	5	5.8	5.8	61.6
102.00	2	2.3	2.3	64.0
103.00	3	3.5	3.5	67.4
104.00	1	1.2	1.2	68.6
105.00	3	3.5	3.5	72.1
106.00	3	3.5	3.5	75.6
107.00	2	2.3	2.3	77.9
108.00	2	2.3	2.3	80.2
109.00	2	2.3	2.3	82.6
110.00	2	2.3	2.3	84.9
111.00	2	2.3	2.3	87.2
112.00	3	3.5	3.5	90.7
114.00	1	1.2	1.2	91.9
116.00	2	2.3	2.3	94.2
117.00	1	1.2	1.2	95.3
121.00	1	1.2	1.2	96.5
124.00	1	1.2	1.2	97.7
125.00	1	1.2	1.2	98.8
128.00	1	1.2	1.2	100.0
Total	86	100.0	100.0	

OSUMATT

```
  Count   Midpoint      One symbol equals approximately    .40 occurrences

      1      69      I***
      0      72      I
      4      75      I**********
      2      78      I*****
      5      81      I*************
      1      84      I***
      4      87      I**********
      4      90      I**********
     15      93      I**************************************
      9      96      I***********************
      3      99      I********
     10     102      I*************************
      7     105      I******************
      6     108      I***************
      7     111      I******************
      1     114      I***
      3     117      I*********
      1     120      I***
      1     123      I***
      1     126      I***
      1     129      I***
              +----+----+----+----+----+----+----+----+----+----+
              0         4         8        12        16        20
                              Histogram frequency
```

Mean	97.919	Std err	1.322	Median	97.000
Mode	92.000	Std dev	12.255	Variance	150.193
Kurtosis	-.204	S E Kurt	.514	Skewness	.072
S E Skew	.260	Range	58.000	Minimum	70.000
Maximum	128.000	Sum	8421.000		

Valid cases   86   Missing cases   0

Power as Knowing Participation in Change (PKPCT) Frequency Scores

Value	Frequency	Percent	Valid Percent	Cum Percent
158.00	1	1.2	1.2	1.2
185.00	1	1.2	1.2	2.4
186.00	1	1.2	1.2	3.6
199.00	1	1.2	1.2	4.8
201.00	1	1.2	1.2	6.0
206.00	1	1.2	1.2	7.1
217.00	1	1.2	1.2	8.3
220.00	1	1.2	1.2	9.5
221.00	1	1.2	1.2	10.7
224.00	1	1.2	1.2	11.9
230.00	1	1.2	1.2	13.1
231.00	1	1.2	1.2	14.3
237.00	1	1.2	1.2	15.5
249.00	1	1.2	1.2	16.7
250.00	1	1.2	1.2	17.9
251.00	1	1.2	1.2	19.0
253.00	1	1.2	1.2	20.2
255.00	1	1.2	1.2	21.4
257.00	1	1.2	1.2	22.6
260.00	1	1.2	1.2	23.8
263.00	2	2.3	2.4	26.2
264.00	2	2.3	2.4	28.6
267.00	1	1.2	1.2	29.8
270.00	1	1.2	1.2	31.0
275.00	1	1.2	1.2	32.1
277.00	1	1.2	1.2	33.3
278.00	1	1.2	1.2	34.5
279.00	1	1.2	1.2	35.7
280.00	2	2.3	2.4	38.1
284.00	1	1.2	1.2	39.3
289.00	3	3.5	3.6	42.9
290.00	2	2.3	2.4	45.2
291.00	2	2.3	2.4	47.6
292.00	1	1.2	1.2	48.8
294.00	1	1.2	1.2	50.0
298.00	2	2.3	2.4	52.4
301.00	1	1.2	1.2	53.6
303.00	1	1.2	1.2	54.8
304.00	1	1.2	1.2	56.0
305.00	2	2.3	2.4	58.3
307.00	1	1.2	1.2	59.5
309.00	2	2.3	2.4	61.9
310.00	2	2.3	2.4	64.3
311.00	1	1.2	1.2	65.5
312.00	2	2.3	2.4	67.9
313.00	1	1.2	1.2	69.0
314.00	4	4.7	4.8	73.8
315.00	3	3.5	3.6	77.4
316.00	1	1.2	1.2	78.6
317.00	1	1.2	1.2	79.8
318.00	1	1.2	1.2	81.0
322.00	1	1.2	1.2	82.1
325.00	1	1.2	1.2	83.3
328.00	1	1.2	1.2	84.5
335.00	1	1.2	1.2	85.7
337.00	2	2.3	2.4	88.1
338.00	1	1.2	1.2	89.3
339.00	1	1.2	1.2	90.5
341.00	1	1.2	1.2	91.7
342.00	2	2.3	2.4	94.0
347.00	1	1.2	1.2	95.2
351.00	2	2.3	2.4	97.6
362.00	1	1.2	1.2	98.8
364.00	1	1.2	1.2	100.0

SUMPOWER

Count	Midpoint	One symbol equals approximately .40 occurrences
1	161	I***
0	171	I
1	181	I***
1	191	I***
2	201	I*****
1	211	I***
4	221	I**********
2	231	I*****
1	241	I***
5	251	I************
6	261	I***************
3	271	I********
6	281	I***************
9	291	I**********************
7	301	I*****************
16	311	I**
5	321	I************
2	331	I*****
7	341	I*****************
3	351	I********
2	361	I*****

```
+----+----+----+----+----+----+----+----+----+----+
0         4         8         12        16        20
                  Histogram frequency
```
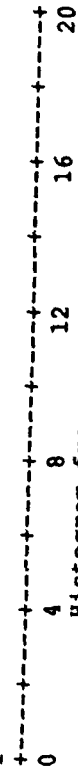
109-Feb-93 SPSS RELEASE 4.0 FOR IBM VM/CMS
14:06:32   UNIVERSITY OF TEXAS AT AUSTIN   IBM 3081-D   VM/SP CMS   Page 13

0SUMPOWER

Mean	287.726	Std err	4.802	Median	296.000
Mode	314.000	Std dev	44.009	Variance	1936.755
Kurtosis	.223	S E Kurt	.520	Skewness	-.748
S E Skew	.263	Range	206.000	Minimum	158.000
Maximum	364.000	Sum	24169.000		

0Valid cases   84   Missing cases   2

Caring Ability Inventory (CAI) Frequency Scores

Value	Frequency	Percent	Valid Percent	Cum Percent
147.00	1	1.2	1.2	1.2
151.00	1	1.2	1.2	2.3
159.00	1	1.2	1.2	3.5
169.00	1	1.2	1.2	4.7
171.00	1	1.2	1.2	5.8
176.00	2	2.3	2.3	8.1
178.00	1	1.2	1.2	9.3
179.00	2	2.3	2.3	11.6
182.00	1	1.2	1.2	12.8
183.00	4	4.7	4.7	17.4
185.00	1	1.2	1.2	18.6
186.00	1	1.2	1.2	19.8
188.00	1	1.2	1.2	20.9
193.00	2	2.3	2.3	23.3
195.00	2	2.3	2.3	25.6
196.00	3	3.5	3.5	29.1
198.00	2	2.3	2.3	31.4
200.00	1	1.2	1.2	32.6
201.00	3	3.5	3.5	36.0
202.00	3	3.5	3.5	39.5
203.00	1	1.2	1.2	40.7
204.00	1	1.2	1.2	41.9
205.00	3	3.5	3.5	45.3
206.00	1	1.2	1.2	46.5
207.00	1	1.2	1.2	47.7
208.00	3	3.5	3.5	51.2
209.00	3	3.5	3.5	54.7
210.00	3	3.5	3.5	58.1
212.00	1	1.2	1.2	59.3
213.00	1	1.2	1.2	60.5
214.00	3	3.5	3.5	64.0
215.00	4	4.7	4.7	68.6
216.00	3	3.5	3.5	72.1
217.00	4	4.7	4.7	76.7
218.00	2	2.3	2.3	79.1
219.00	2	2.3	2.3	81.4
220.00	2	2.3	2.3	83.7
222.00	1	1.2	1.2	84.9
224.00	3	3.5	3.5	88.4
225.00	1	1.2	1.2	89.5
226.00	1	1.2	1.2	90.7
227.00	1	1.2	1.2	91.9
229.00	3	3.5	3.5	95.3
232.00	1	1.2	1.2	96.5
233.00	1	1.2	1.2	97.7
239.00	1	1.2	1.2	98.8
249.00	1	1.2	1.2	100.0

SUMCARE

```
                        Total   ------  ------  ------
                                  86    100.0   100.0

                        One symbol equals approximately   .40 occurrences

Count   Midpoint
  1       148    I***
  1       153    I***
  1       158    I***
  0       163    I
  1       168    I***
  1       173    I***
  5       178    I*************
  6       183    I***************
  2       188    I******
  4       193    I***********
  6       198    I***************
 11       203    I****************************
 11       208    I****************************
  9       213    I***********************
 13       218    I*********************************
  5       223    I*************
  5       228    I*************
  2       233    I******
  1       238    I***
  0       243    I
  1       248    I***
                 I----+----+----+----+----+----+----+----+----+----+
                 0    4    8    12   16   20
                        Histogram frequency
```

Mean	204.791	Std err	2.063	Median	208.000
Mode	183.000	Std dev	19.133	Variance	366.073
Kurtosis	.681	S E Kurt	.514	Skewness	-.700
S E Skew	.260	Range	102.000	Minimum	147.000
Maximum	249.000	Sum	17612.000		

Valid cases   86   Missing cases   0

Comparative Scores Reported by Case

of NATMI (SUMATT), CAI (SUMCARE) and PKPCT (SUMPOWER)

ID	SUMATT	SUMCARE	SUMPOWER
101	102.00	219.00	263.00
103	96.00	227.00	298.00
106	92.00	213.00	199.00
107	90.00	195.00	290.00
108	103.00	214.00	314.00
109	94.00	220.00	305.00
110	81.00	216.00	339.00
113	94.00	179.00	217.00
114	97.00	196.00	237.00
118	93.00	217.00	307.00
120	116.00	224.00	304.00
124	105.00	196.00	313.00
125	101.00	220.00	278.00
126	94.00	176.00	220.00
127	112.00	206.00	311.00
130	109.00	208.00	275.00
133	95.00	210.00	322.00
134	108.00	188.00	310.00
135	117.00	219.00	338.00
137	110.00	229.00	335.00
138	106.00	229.00	337.00
139	105.00	179.00	264.00
141	101.00	212.00	314.00
142	81.00	208.00	316.00
144	96.00	208.00	292.00
146	99.00	217.00	342.00
147	109.00	217.00	277.00
148	92.00	207.00	249.00
152	87.00	209.00	290.00
153	125.00	232.00	314.00
154	82.00	201.00	291.00
155	107.00	147.00	201.00
161	92.00	205.00	312.00
162	75.00	210.00	309.00
165	97.00	186.00	270.00
168	92.00	195.00	303.00
169	103.00	215.00	314.00
170	81.00	171.00	206.00
171	124.00	218.00	341.00
172	110.00	216.00	315.00
173	99.00	218.00	298.00
174	108.00	239.00	347.00
175	97.00	198.00	280.00
176	83.00	205.00	221.00
178	92.00	233.00	362.00
179	92.00	202.00	279.00
180	95.00	193.00	301.00
181	102.00	201.00	315.00
182	107.00	183.00	315.00
183	79.00	215.00	305.00
185	86.00	183.00	255.00

ID	SUMATT	SUMCARE	SUMPOWER
186	91.00	182.00	264.00
187	96.00	151.00	263.00
188	78.00	176.00	250.00
189	88.00	196.00	267.00
192	128.00	229.00	351.00
194	70.00	185.00	230.00
197	121.00	215.00	291.00
199	112.00	224.00	294.00
201	88.00	205.00	.
203	90.00	222.00	318.00
206	103.00	209.(?)	280.00
207	111.00	225.00	328.00
208	106.00	202.00	312.00
211	98.00	201.00	309.00
212	116.00	204.00	.
214	106.00	226.00	337.00
216	111.00	183.00	310.00
217	112.00	249.00	351.00
219	91.00	215.00	325.00
220	92.00	178.00	231.00
223	76.00	214.00	185.00
224	105.00	216.00	260.00
225	76.00	217.00	186.00
227	82.00	169.00	224.00
228	93.00	159.00	257.00
230	76.00	203.00	158.00
231	101.00	193.00	289.00
232	92.00	210.00	284.00
233	114.00	214.00	364.00
235	101.00	198.00	317.00
238	101.00	224.00	342.00
240	104.00	183.00	253.00
243	95.00	209.00	251.00
244	92.00	202.00	289.00
245	92.00	200.00	289.00

-Number of cases read: 86   Number of cases listed: 86
109-Feb-93 SPSS RELEASE 4.0 FOR IBM VM/CMS
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Frequency Statistics for Instruments

0Number of valid observations (listwise) = 84.00
0Variable SUMATT

Mean	97.919	S.E. Mean	1.322
Std Dev	12.255	Variance	150.193
Kurtosis	-.204	S.E. Kurt	.514
Skewness	.072	S.E. Skew	.260
Range	58.000	Minimum	70.00
Maximum	128.00	Sum	8421.000

0Valid observations - 86   Missing observations - 0
0- -
0Variable SUMCARE

Mean	204.791	S.E. Mean	2.063
Std Dev	19.133	Variance	366.073
Kurtosis	.681	S.E. Kurt	.514
Skewness	-.700	S.E. Skew	.260
Range	102.000	Minimum	147.00
Maximum	249.00	Sum	17612.000

0Valid observations - 86   Missing observations - 0
0- -
0Variable SUMPOWER

Mean	287.726	S.E. Mean	4.802
Std Dev	44.009	Variance	1936.755
Kurtosis	.223	S.E. Kurt	.520
Skewness	-.748	S.E. Skew	.263
Range	20r.000	Minimum	158.00
Maximum	364.00	Sum	24169.000

0Valid observations - 84   Missing observations - 2
109-Feb-93 SPSS RELEASE 4.0 FOR IBM VM/CMS
 14:06:31 UNIVERSITY OF TEXAS AT AUSTIN IBM 3081-D   VM/SP CMS

APPENDIX H

CORRELATION MATRIX and SCATTERPLOTS of VARIABLES

Pearson r Correlation Matrix of Attitude, Power and Caring Variables

```
3   CORRELATION VARIABLES=CARING ATTITUDE
4           /VARIABLES=CARING POWER
5           /VARIABLES=POWER ATTITUDE
6
0PEARSON CORR problem requires 240 bytes of workspace.
109-Feb-93 SPSS RELEASE 4.0 FOR IBM VM/CMS
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                    - - Correlation Coefficients  - -


             CARING      ATTITUDE

CARING      1.0000       .3081**
ATTITUDE     .3081**    1.0000
0* - Signif. LE .05      ** - Signif. LE .01      (2-tailed)
0" . " is printed if a coefficient cannot be computed
109-Feb-93 SPSS RELEASE 4.0 FOR IBM VM/CMS
 13:33:15  UNIVERSITY OF TEXAS AT AUSTIN   IBM 3081-D      VM/SP CMS


                    - - Correlation Coefficients  - -


             CARING      POWER

CARING      1.0000       .5532**
POWER        .5532**    1.0000
0* - Signif. LE .05      ** - Signif. LE .01      (2-tailed)
0" . " is printed if a coefficient cannot be computed
109-Feb-93 SPSS RELEASE 4.0 FOR IBM VM/CMS
 13:33:15  UNIVERSITY OF TEXAS AT AUSTIN   IBM 3081-D      VM/SP CMS


                    - - Correlation Coefficients  - -


             POWER       ATTITUDE

POWER       1.0000       .5159**
ATTITUDE     .5159**    1.0000
0* - Signif. LE .05      ** - Signif. LE .01      (2-tailed)
0" . " is printed if a coefficient cannot be computed
109-Feb-93 SPSS RELEASE 4.0 FOR IBM VM/CMS
 13:33:15  UNIVERSITY OF TEXAS AT AUSTIN   IBM 3081-D      VM/SP CMS
```

Scatterplot of Caring with Attitude

```
* * * * * * * * * * * * * * * * *  P  L  O  T  * * * * * * * * * * * * * * * * * *

Data    Information

        86 unweighted cases accepted.

Size of the plots

    Horizontal size is 65
      Vertical size is 40


                             PLOT OF CARING WITH ATTITUDE
          ++----+----+----+----+----+----+----+----+----+----+----+----+----++
      280+                                                                    +
         I                                                                    I
         I                                                                    I
         I                                                                    I
         I                                                                    I
      260+                                                                    +
         I                                                                    I
         I                                                                    I
         I                                            1                       I
         I                                                                    I
      240+                                        1                           +
         I                                                                    I
         I                          1                                         I
         I                              1             2   1               1   I
         I                      1                 1         11  1            1 I
      220+                         1        1 11               1     1        +
         I            2  1 1           1 1       1   2 1    11  1      1       I
    C    I          1               2 1       1                              I
    A    I                1  1     1 11          1      1 1                   I
    R    I          1        1   1   3            1          1               I
    I 200+                 1          1    11  11                            +
    N    I               1 1 1        1       1                              I
    G    I                          1       1                                I
         I                          1                                        I
         I      1              1     1           1 1  1                       I
      180+                          1 1         1                            +
         I             1               1                                     I
         I               1          1                                        I
         I                1                                                  I
         I                                                                    I
      160+                        1                                          +
         I                                                                    I
         I                         1                                         I
         I                             1                                      I
         I                                                                    I
      140+                                                                    +
         I                                                                    I
         I                                                                    I
         I                                                                    I
         I                                                                    I
      120+                                                                    +
          ++----+----+----+----+----+----+----+----+----+----+----+----+----++
          65        75        85        95       105       115       125


                                     ATTITUDE

        86 cases plotted.
```

Scatterplot of Power with Attitude

`* * * * * * * * * * * * * * * * * P  L  O  T * * * * * * * * * * * * * * * * * *`

Data   Information

      86 unweighted cases accepted.

Size of the plots

   Horizontal size is 65
     Vertical size is 40

```
                              PLOT OF POWER WITH ATTITUDE
          ++----+----+----+----+----+----+----+----+----+----+----+----+----++
     450+                                                                     +
        I                                                                     I
        I                                                                     I
        I                                                                     I
        I                                                                     I
     400+                                                                     +
        I                                                                     I
        I                                                                     I
        I                     1                   1    1          1           I
        I                                                                     I
     350+                                        1   1        1         1     +
        I          1                  1 1    2   1        1         1         I
        I                        1                   1                        I
        I             1       1        1     11   1  1                        I
        I      1   1          111    1  1 2 11 1  11          1               I
     300+                     1 11  1      1              1        1          +
        I             1    1  1 2  1       1             1           1        I
P       I                    2    1     1 1          2                        I
O       I                1        1                                           I
W       I              1   1 1 1      1 2                                     I
E    250+          1         1 1         1                                    +
R       I      1              1                                               I
        I                     1                                               I
        I             11       2                                              I
        I          1                                                          I
     200+                    1             1                                  +
        I      2                                                              I
        I                                                                     I
        I      1                                                              I
     150+                                                                     +
        I                                                                     I
        I                                                                     I
        I                                                                     I
     100+                                                                     +
        I                                                                     I
        I                                                                     I
        I                                                                     I
      50+----+----+----+----+----+----+----+----+----+----+----+----+----+----++
        65        75        85        95       105       115       125
```

                              ATTITUDE

      84 cases plotted.

Scatterplot of Caring with Power

```
* * * * * * * * * * * * * * * * *  P  L  O  T  * * * * * * * * * * * * * * * * * * *

Data    Information

        86 unweighted cases accepted.

Size of the plots

    Horizontal size is 65
      Vertical size is 40
```
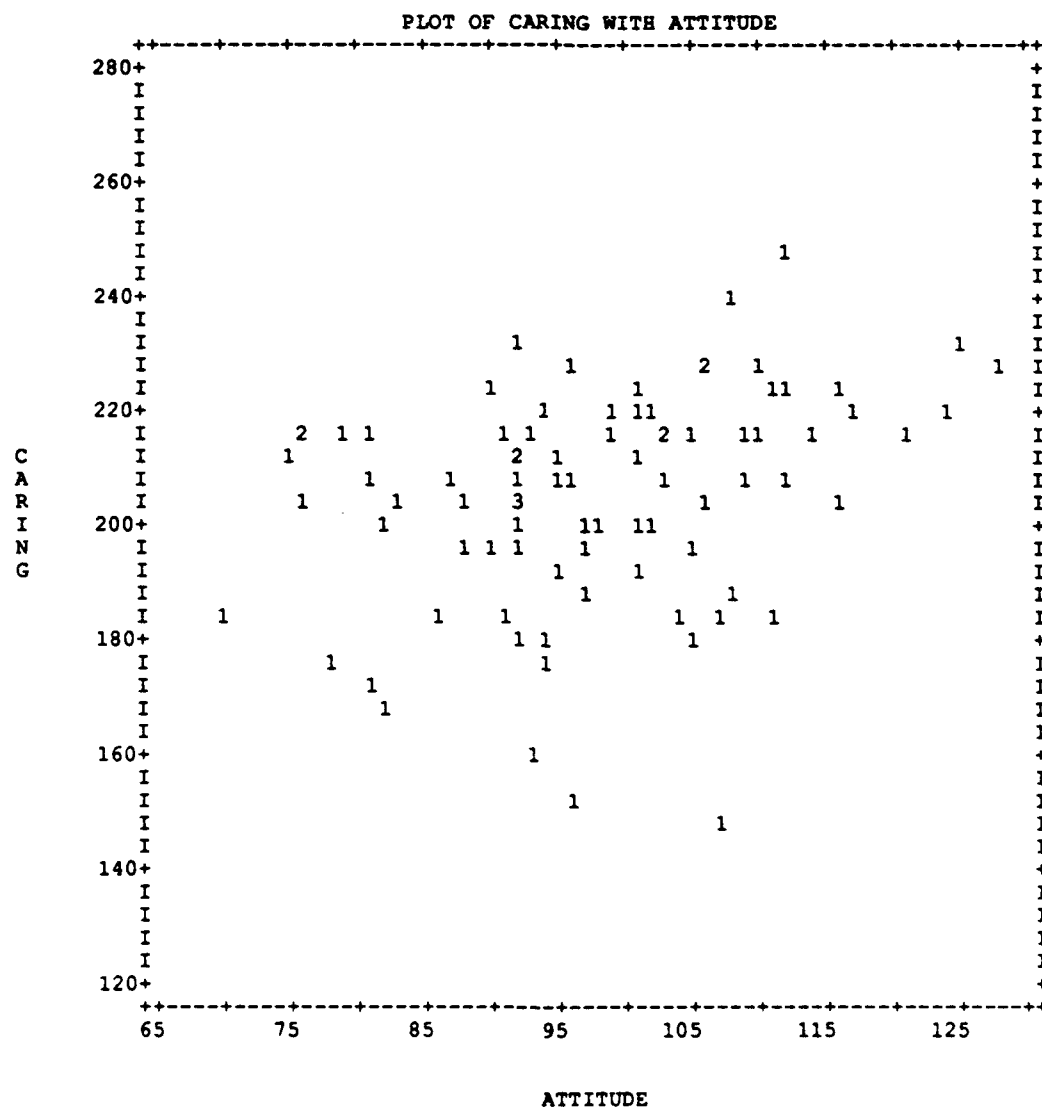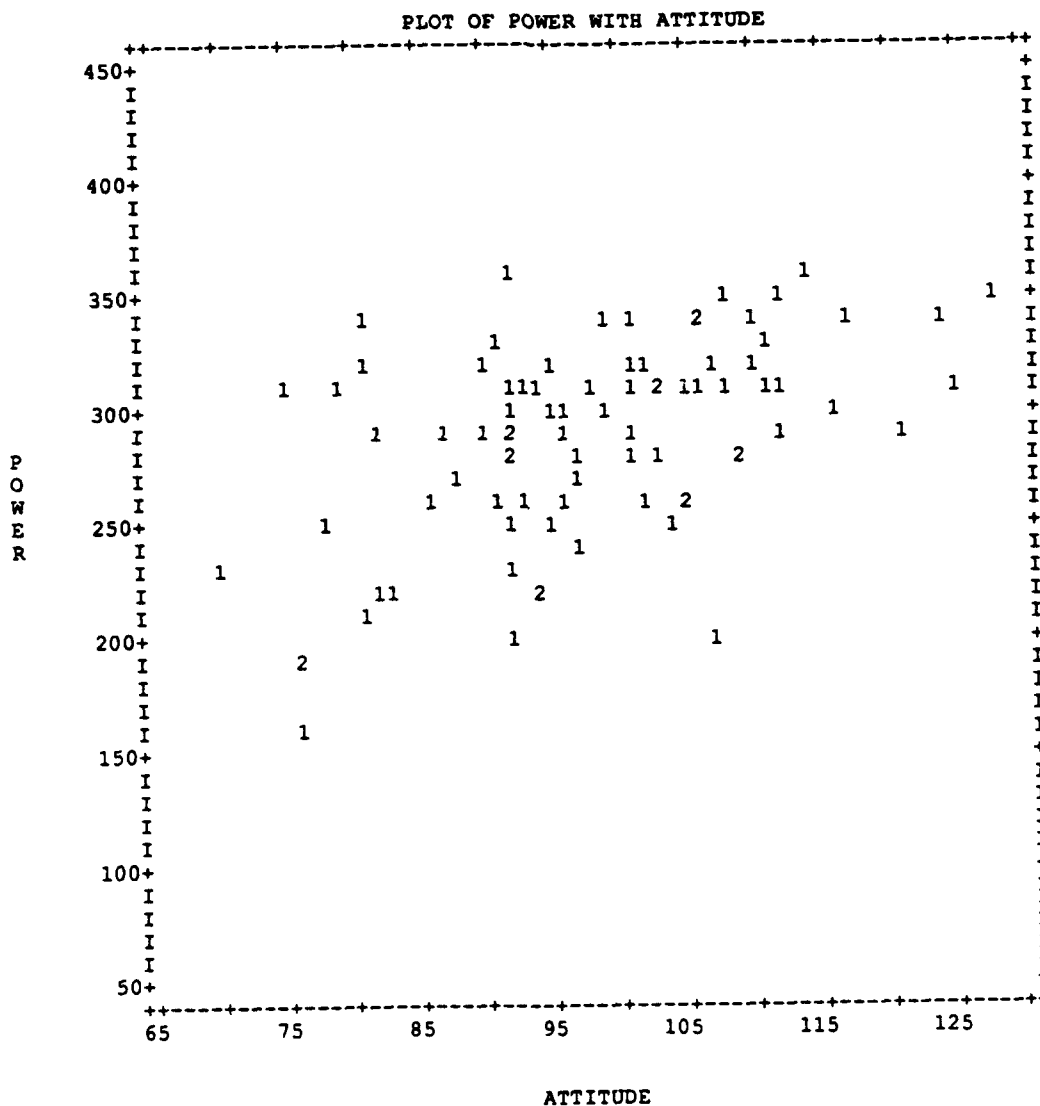
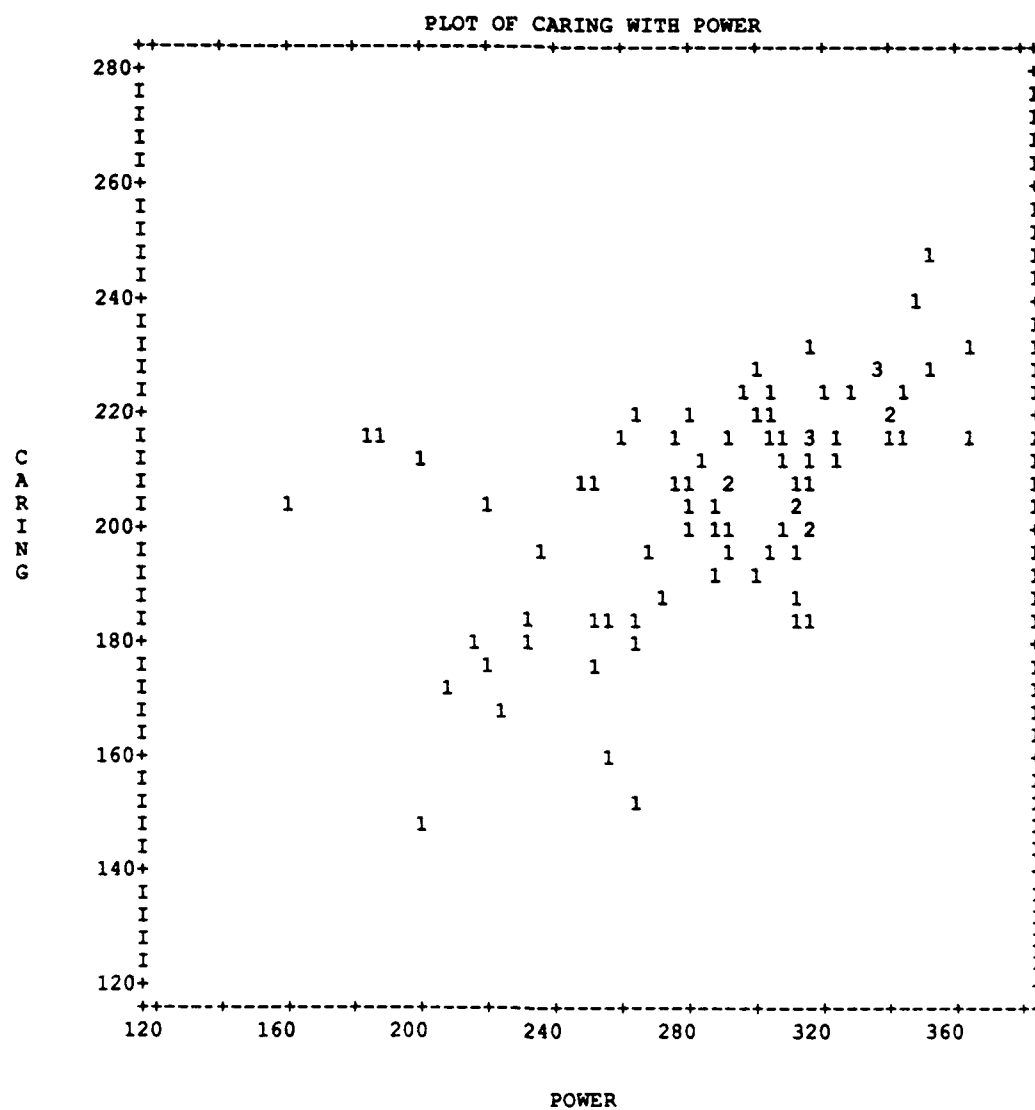```
                              PLOT OF CARING WITH POWER
        ++----+----+----+----+----+----+----+----+----+----+----+----+----++
    280+   +
       I   I
       I   I
       I   I
       I   I
    260+   +
       I   I
       I   I
       I   1   I
       I   I
    240+   1   +
       I   I
       I   1   I
       I   1   3 1   I
       I   1 1   1 1   1   I
    220+   1   1   11   2   +
  C   I   11   1   1 11 3 1   11   1   I
  A   I   1   1   1 1 1   I
  R   I   11   11 2   11   I
  I   I   1   1   1 1   2   I
    200+   1 11   1 2   +
  N   I   1   1   1 1 1   I
  G   I   1 1   I
       I   1   1   I
       I   1   11 1   11   I
    180+   1   1   1   +
       I   1   1   I
       I   1   1   I
       I   1   I
       I   I
    160+   1   +
       I   I
       I   1   I
       I   1   I
       I   I
    140+   +
       I   I
       I   I
       I   I
       I   I
    120+   +
        ++----+----+----+----+----+----+----+----+----+----+----+----+----++
        120   160   200   240   280   320   360
```

POWER

        84 cases plotted.

# APPENDIX I

## SPEARMAN CORRELATION COEFFICIENT MATRIX
## of BIOGRAPHICAL VARIABLES

- - - - - S P E A R M A N   C O R R E L A T I O N   C O E F F I C I E N T S - - - - -

| | AGE | ED | YRSRN | YRSCIVRN | YRSAFRN | POS | SHIFT | RANK |
|---|---|---|---|---|---|---|---|---|
| **ATTITUDE** | .2740<br>N( 86)<br>SIG .005 | .3094<br>N( 86)<br>SIG .002 | .4139<br>N( 86)<br>SIG .000 | .0927<br>N( 84)<br>SIG .201 | .3414<br>N( 86)<br>SIG .001 | .3165<br>N( 86)<br>SIG .001 | .2115<br>N( 86)<br>SIG .025 | .2814<br>N( 86)<br>SIG .004 |
| **CARING** | .1656<br>N( 86)<br>SIG .064 | .4157<br>N( 86)<br>SIG .000 | .2023<br>N( 86)<br>SIG .031 | -.1353<br>N( 84)<br>SIG .110 | .2383<br>N( 86)<br>SIG .014 | .1617<br>N( 86)<br>SIG .068 | .1027<br>N( 86)<br>SIG .173 | .2326<br>N( 86)<br>SIG .016 |
| **POWER** | .2284<br>N( 84)<br>SIG .018 | .3155<br>N( 84)<br>SIG .002 | .3173<br>N( 84)<br>SIG .002 | .0059<br>N( 82)<br>SIG .479 | .3234<br>N( 84)<br>SIG .001 | .3145<br>N( 84)<br>SIG .002 | .3036<br>N( 84)<br>SIG .002 | .2903<br>N( 84)<br>SIG .004 |

# APPENDIX H

## QUALITATIVE RAW DATA

\* Any information provided that might reveal the identity of a subject
has been changed to maintain confidentiality.

Question # 129 from the Biographical Data Survey:   Please describe any
aspects of your environment which affects your ability to care for patients.

**101**

- Lack of supportive services such as ward clerks

- This questionnaire I didn't get to complete because of busy work load

- We work our nursing staff hard, not always in  professional roles

- Not much opportunity for staff professional growth

- I don't have the opportunity to teach as a manager because I am
expected to do direct patient care

**106**

- Lack of being taken seriously and being viewed by physicians and
supervisors as the experienced, well educated psychiatric nurse

- Interventions by nurses are discounted and other treatment modalities are
given credit for patients' progress

- Nurses give 24 hour a day coverage when doctors only see the
patients twice a week

- Lack of professional grooming and pats on the back by supervisors and
peers results in less than adequate patient care

**108**

- Lack of staff motivation and investment

- Insufficient staff

- Repeated change in policy

- Lack of commitment from hospital commander level

- Old facility

- Lack of investment in physical environment

- "Self-Serving" staff

- Lack of value towards mental health nursing by higher-ups

- Lack of knowledge of mental health nursing of executives/nursing administration level

**109**

- Too many people with "problems" coming into the Air Force with high rank

- My last psychiatric assignment

**110**

- Administrative duties that take time away from the unit & patient

- Staffing; fighting to keep the minimal staffing that we have

- Poor decisions & management/leadership from my chain of command

- Hidden agendas by others who impact the unit but are not directly involved day-to-day

**118**

- Air Force mental health nursing is 20 years behind civilian jobs

- Doing work with psych patients that was done 20 years ago

- Lack of experience of mental health nurses in psych mental health

- Environment is angry and hostile with focus on schedule and not on patients

- Change is slow and almost non-existent

- Mental health nursing is disappointing to me

- I can't wait to leave the system

**120**

- Administrative duties do not allow time or opportunity to be involved in patient care

- I have worked with nurses who were very dynamic making nursing fun and valuable

- These nurse placed the clients first and foremost in their activities

- These nurses respected each other as professionals and were receptive to teaching one another and learning from one another

- On the other side of the coin, I have worked with nurses who knew very little about themselves, let alone the ability to help others

- Some nurses are self-absorbed, self-righteous, resistive to any feedback

- Many nurses blame the military for their miseries

- I find the military system no different than any other bureaucratic system

- The ability to adapt, to be flexible, to adjust to varying situations have been keys to my success

- The higher in rank, the more administrative duties

- Nurses seem more incline to "flex their muscles" engaging in power struggles with physicians

- Nurses bitch and complain about what they don't have and about one another

- There is little time left to develop empathy and get involved with patients

125

- Currently the chief of in-patient services (doctor) is very security conscious and therefore sets the tone on the unit

- The patients are in pajamas for quite awhile, they progress slowly through the category system

- The staff spends a lot of man hours "guarding" the patients on 1:1

126

- Low staffing; nurses on 12 hour shifts, charge nurse performing staff nurse duties 75-80 % of the time

- Perceived lack of concern, understanding and support from hospital nursing administration and hospital administration

- Mental health nursing is viewed as much less important than med/surg, ER, OB/Gyn, or other "true" nursing units

- Mental health nurses have been used to supplement other units staffing (med/surg) but medical nurses do not fill in on psych

**127**

- Lack of staffing, must perform direct patient care as well as administrative duties

- TQM and interest of the chief nurse in improving patient care are positive influences

**130**

- Lack of nurses has lead to decrease in patient interaction and teaching patient education classes and decrease in personal satisfaction

- I feel our patient category system and amount of control we have on patients dehumanizes and decreases feelings of self-worth. It also promotes feelings of illness

- The unit has become less restrictive with a change in physicians and other staff

- Nurses input into patient care is greater than compared to civilian nursing

- There are opportunities to have positive effects on patients with teaching classes, increase coping skills, and 1:1 counseling

**135**

- Not taking patients clothes away from them in an effort to decrease the dehumanizing effect of hospitalization

- We quit treating the patients with "potential for" and used our nursing assessment skills in determining (along with the patient) how much restriction they require

- When you start listening to the patients, they will tell you what they need

- Before this, we dictated/told patients what we would do for them and what they needed to change

**138**

- Limited patient census (varies sporadically from 2-16 in a very short period of time) affects milieu environment

- It is difficult to have group therapy with only two patients

- There is a lot of creativity and autonomy allowed with strong TQM support from management

**141**

- Lack of space, ie., seclusion rooms, day area, quiet rooms, visiting rooms

**142**

- Physician facilitated staff splitting

**144**

- Very inadequate staffing

**146**

- Poor physical plant

- Not enough staff!

**147**

- Lack of support from unit manager

- MD who ignores nurses input

- Admissions of 2 months and longer

**152**

- Lack of adequate supplies

- Aesthetic ugliness; old carpet with wild stripes that make patients dizzy

- Rotating 12 hour shifts and then having to perform military duties, meetings on days off

- All staff feel very tired and irritable

- Disruption in circadian rhythm creates for poor continuity in patient care

**153**

- Staffing

**162**

- Other staff and the administrative lack of insight of the Air Force medical service, in general, hinder me in providing total quality care to patients

- The nursing leadership does not value psychiatry or substance abuse treatment due to their biases

- Psych nurses transferred to medical units against their will when we had staff shortages

- Psychiatry during war time (Desert Storm) was completely devalued and no psych nurses were sent, even though statistics show a large percentage of casualties are psychiatric

- The country in general and the military leadership are in denial as to the problem and they discriminate accordingly

- I am getting out of the Air Force after my tour and I am getting out of patient care and work in some paperwork job at an insurance company

**168**

- I feel patients receive excellent care

- Staff works closely with a psychiatrist and psychologist and is involved in all patient decisions

- All planning is done together with the patient; input from the patient is important

- Family involvement or finding a support system for a patient is important, especially living overseas

**170**

- I'm getting out of the Air Force or into AF OR nursing.  I guess I'm burned out.

**171**

- Control issues between different disciplines

- Non-assertive attribute by the department of nursing

**172**

- 12 hour shifts

- Short hospital stays; unit is crisis oriented

- Minimal staffing

- Census is often too low for patients to experience the power of group therapy

**173**

- Lack of staff

- Staff has multiple roles; we are not only nurses or technicians, we are also QA monitors, standards committee members, etc., etc.

  These roles while important also place demands on our time detract from patient care

**176**

- We have a doctor who has a degree in enabling and we feel powerless and frustrated to change it

- The doctors fosters in patients the sense that they are the only part of their treatment

- Nurses are struggling to gain a more active role in the community

- The notion that mental health workers do not have problems conveys to the patients that we are false and God-like

- The mental health department has the frame of reference that a mental health worker is not allowed to have personal problem

**178**

- We are treated like a personnel pool; when med/surg units need help to get organized we are delegated by our clinical coordinator to go help, regardless of the agenda we may have with our own patients

- Mental health patients continue to suffer the loss of staff availability

- The unspoken message is "The mental health patients are not as important"

**183**

- Lack of dollars

- Lack of equipment

- Antiquated facilities

- Lack of training and personnel

**186**

- Low staffing, high acuity

**189**

- Working 12 hour rotating shifts

**192**

- Staffing, often have to function as only nurse on 12 hour shift with both role of staff and charge nurse

**197**

- Needs for positive support and encouragement of supervisors and superiors within the department of nursing

**199**

- My ability to care for patients has to do with the Air Force itself

- Despite my advanced degree, I am working as a staff nurse. With my degree, I could work in a clinic with prescriptive privileges, as a clinical nurse specialist, or many other areas

- The AF needs bodies to staff psych units and they don't care about education level

- I am disappointed, I thought they would want me for more than a staff nurse

- I do what I can to bring my educational experience and background in as much as possible

**208**

- Always short staffed

- The AF nurse corps does not legitimize the specialty of mental health nursing as they do other specialties

- There are no O-6 slots designated for psychiatric nurses as there are for other specialties, as well as med/surg

- This is a living example that in our nurse corps leadership, psych mental health nursing is not legitimate as a specialty in their minds

- This is sad and a barrier to the progress, development, and support of our specialty

**214**

- Positive aspects: Individual & group counseling, helping patients process their feelings & assisting them to identify problem solving skills in the here and now

- Negative aspects: High census (Pt to staff ratio 30:1 RN) Nurses become a trouble shooter/crisis intervention

**217**

- I have the authority to make decisions on my unit

- The hospital sees us as personnel here to help them

- The chief nurse respects us and our jobs

- Our program has saved CHAMPUS dollars

- We have proven mental health nursing is an active milieu of the administration at our hospital

**223**

- Ineffective charge nurse support of the staff for past several years

**224**

- Excessively long shifts (12 hour) and rotation to nights

- Recent change in management & their tendency to be inflexible

- Military's current state of flux, one never knows if one will have a job

- Shrinking benefits over time

**227**

- Shift rotation effects ability to do the job

- I feel one should be allowed to pick a flex shift

**230**

- The military environment, in my opinion, is a liability and negative influence

- The rank structure rewards superficial, socially adept people while job expertise, commitment to patient care, & being a sound patient advocate is devalued in the face of commitment to the organization, with patient care taking a back seat

- The rigidity of the AF structure does not encourage autonomy in nursing and does not encourage personal growth

- Psychiatric nursing is going to evolve into a mature and respected discipline only if nurses are allowed to be change agents; change is discouraged in the military structure

- Instead of "how can we improve" they follow "if it's not broke, don't fix it"

- In the acute care setting, the focus is on diagnosis and disposition and not on treatment outcomes or resolution

- Any therapy that produces needed change is a bonus but not the actual goal, as seen in the mission statement for the units

- Unfortunately, not seeing positive fruits of their labors in the form of therapeutic interventions is detrimental to morale

- Any behavior which deviates from accepted military behavior is looked at as something to control & dominate

- The principle of least restrictive environment is in direct opposition with military structure, so it's not surprising that it is not practiced


231

- Lack of confidentiality of material disclosed during treatment

233

- Limited staffing when acuity is high

- A positive is that we are empowered to look at alternative delivery models

- The opportunity to be innovative is present

- Compared to other units in the AF, our staffing is excellent (that is in numbers)

- I feel our environment is at an optimum for a paradigm change; one that is for the better

- New nurses with new ideas

- A time to address entitlement and encourage team work and mission accomplishment

- My vision is to see a cohesive high functioning staff that will indirectly improve quality of patient care

243

- One thing that affects my ability to care for patients is the length of time they sometimes remain on the ward

- The Medical/Physical evaluation board process is entirely too long

- Patients end up staying on the ward for months and decompensating

- I am also confused at times of what is our mission, to treat? to evaluate? or to dispose or dump?

- Many times we end up as baby-sitters because unit commanders do not want to discipline or separate people or they get stuck in quagmire or on mental health because of some vague suicidal ideation

- Most patients belong in corrective custody or jail

- I want to help people who need help but many times we are just a safe place for offenders to hang out

- When people can stop calling where we work a "Mental Ward" or "Loony Bin" we and our patients will have a lot more options and understanding about mental health

- Most people, the chief nurse in particular, do not want to be interested in Mental Health

- I've never had anyone stop by and say hello or share information

- People avoid us like the plague

# APPENDIX I

# PERMISSION LETTERS

# HUNTER COLLEGE

of The City University of New York

Hunter-Bellevue School of Nursing • 425 East 25th Street, New York, N.Y. 10010 • (212) 481-4465 & 4465

Director of Graduate Program

This letter is to grant permission to

_____Mary M. Higgins_____

for use of the Power as Knowing Participation in
Change Tool for your thesis.  There is no charge
to students for one time use of the tool for your
research.  However, I do request that you send me
a copy of your completed thesis.

Good luck in your work.

> Elizabeth Ann Manhart Barrett, Ph.D., R.N.
> Associate Professor

EAMB/mb

⊙

**OREGON
HEALTH SCIENCES UNIVERSITY**
3181 S.W. Sam Jackson Park Road, Portland, Oregon 97201-3098   (503)494-7893   FAX (503)494-4350

*School of Nursing*
*Office of Graduate Studies*

June 28, 1992

Mary M. Higgins
10 Ridge Drive
New Braunfels, Texas 78130

Dear Ms. Higgins:

I give you permission to use the tool- Caring Ability Inventory- I
developed in your research. I expect in return that you share with
me the raw data obtained on the Inventory. This will permit
continued studies on the reliability and validity of the inventory
which I am conducting. Your interest and input is greatly
appreciated.

I am presently at Oregon Health Sciences University for a year
after which I will return to Lehman College. You may contact me
with comments and/or questions at:
        Lehman College (CUNY)
        Division of Nursing
        Bedford Park Boulevard West
        Bronx, NY 10468-1589
        (212) 960 8213
        (503) 494 3861-- Oregon Health Sciences University
                during 1992 and 1993

Good luck on your endeavors.

        Sincerely,

        Ngozi O. Nkongho, Ph.D., R.N.

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# VITA

Mary Mickle Higgins was born in Arlington, Virginia, on March 12, 1960, the daughter of Nannette Elliott Mickle and Francis Lauren Mickle. After completing her work at Belleville Township High School West, Belleville, Illinois, she began attending college part-time and working as a nurse's aid at Memorial Hospital in Belleville, Illinois. She received her Associates Degree in the Science of Nursing from Baptist College at Charleston, Charleston, South Carolina in May 1982.

Upon graduation, she was employed as a medical/surgical staff nurse by North Trident Regional Hospital, North Charleston, South Carolina from May - December 1982. From March 1983 - 1985 she was employed as a staff nurse on a medical unit, and from 1985 - 1987 as an assistant charge nurse on an in-patient psychiatric unit at Saint Vincent's Medical Center, Jacksonville, Florida. During this time, she also served on the patient education committee and developed patient teaching brochures on medication administration and electroconvulsive therapy that were used hospital wide. While working full-time at St. Vincent's Medical Center, she attended school at the University of North Florida, Jacksonville, Florida, and received her Bachelor of Science in Nursing in August 1987. Mary received her certification by the American Nurses' Association in mental health nursing in October 1987.

In December 1987, she entered active duty in the U. S. Air Force Nurse Corps. From December 1987 - July 1991 she was employed as a mental health staff nurse at the U. S. Air Force Medical Center Wright-Patterson, Wright-Patterson Air Force Base, Ohio. In August 1991, she was accepted to the Air Force Institute of Technology graduate program and entered the Graduate School of the University of Texas School of Nursing at Austin, while remaining on active duty in the Air Force.

The degree of Master of Science in Nursing will be awarded to her in May 1993, after which she will continue to serve as a Captain in the U. S. Air Force and will be assigned to work in in-patient mental health as a staff nurse at Wilford Hall Medical Center, Lackland Air Force Base, Texas. Mary is a member of Sigma Theta Tau, Lambda Rho Chapter and the American Psychiatric Nurses' Association.

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